A Guide to

Understanding Mental Health Systems and Services in Texas

2012

Hogg Foundation *for* Mental Health

ADVANCING RECOVERY AND WELLNESS IN TEXAS

Acknowledgements

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Hogg Foundation for Mental Health

The Hogg Foundation for Mental Health has been promoting mental health in Texas since 1940, when the children of former Texas Governor James S. Hogg established the foundation at The University of Texas at Austin.

Over the years, the foundation has awarded millions of dollars in grants to continue the Hogg family's legacy of public service and dedication to improving mental health in Texas. Other donors have established smaller endowments at the foundation to support its mission. Today the foundation continues to support mental health services, research, policy analysis and public education projects in Texas. The foundation focuses its grant making on key strategic areas in mental health and awards grants through a competitive proposal process.

The foundation is part of the Division of Diversity and Community Engagement at The University of Texas at Austin. For more information, visit **www.hogg.utexas.edu**.

Language Usage

Behavioral health is the term typically used when referring to mental health and substance use. The foundation acknowledges the ongoing discussions and differing perspectives about utilizing the term "behavioral health" and "mental health." In this document, the Hogg Foundation uses the term "behavioral health" when referring to both mental health and substance use services and supports. Our belief is that the priority goal of behavioral health policy must be recovery.

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Overview

Behavioral health services in Texas are provided through a complex maze of programs that vary widely across the state. The range of available services may be different depending on where consumers live, individual and family income, age, access to private or public insurance, type of symptoms, severity of the condition, and the availability of health care providers who can provide the needed care within a reasonable distance. Navigating this system is often frustrating even for the most informed providers and clinicians who support individuals on a daily basis. For policymakers, family members and consumers (those who are receiving or have received mental health services) who have little experience or knowledge of this system of care, understanding the complexities of the patchwork of behavioral health care services is particularly challenging.

The purpose of this report is to provide a general overview of the behavioral health care delivery system and the services provided under various state agencies that are funded in full or in part with state appropriations. To ensure this document is a useful reference tool, it does not provide significant detail on the various programs but instead focuses on the general infrastructure, funding and services provided. The report is designed to provide the reader with a basic understanding of how behavioral health services are provided, the population that is served, and the challenges of meeting the growing and often unmet needs of Texans with mental health or substance use conditions. For policymakers who struggle with many complex matters and decisions, we hope this report will be a useful guide, providing practical and accurate information on mental health services in Texas.

Individuals can enter the behavioral health system through multiple points of entry.

The report is divided into the following six general categories:

- National Context: A basic overview of national activities related to behavioral health care services, including a discussion of federal requirements that impact the types of benefits that may be provided and the populations served under the Patient Protection and Affordable Care Act (ACA).
- The Texas Environment: A discussion of current issues and recent developments at the state level, including a description of new programs and organizational approaches to care, some of which are being implemented and others that may require legislative action during the 2013 session of the Texas Legislature.
- Public Behavioral Health Services in Texas: An overview of the multiple Texas state agency programs that provide a wide range of behavioral health services for clients, including programs provided by health and human services agencies and services administered by criminal justice agencies, school districts and the Texas Education Agency, and the Texas Department of Housing and Community Affairs.
- Medicare and Private Insurance: A description of benefits and requirements for behavioral health services under Medicaid, Medicare and private insurance plans.

- Best Practices and Policy Priorities: A discussion of best practices and current policy priorities for providing behavioral health services, including a discussion of such topics as the integration of primary and behavioral health care services to provide a more efficient and coordinated level of care; prevention and early intervention initiatives; and addressing the behavioral health needs of individuals accessing services through the criminal justice system.
- Mental Health Workforce Shortages: A discussion of the shortage of providers and clinicians serving the Texas population and the challenges of attracting, educating and maintaining a qualified and adequate workforce to meet current and future needs of Texans with behavioral health care needs.

Also included at the end of this report is a glossary of commonly used terms. However, some programs are subject to very specific, technical definitions in state or federal statutes that may vary from the more commonly used definitions included in this report. For that reason, readers may want to refer to additional resources noted throughout this document for more comprehensive information about a specific program.

The Hogg Foundation wants to emphasize that this report focuses primarily on state programs for treating behavioral health care needs in Texas. Many communities and providers throughout the state are equally engaged in the development, implementation and oversight of locally operated (and often locally funded) programs and services that are more specifically designed to serve the needs of local residents. Due to the variations in programs and the lack of a central database that identifies these various resources, this report generally does not include programs created at the local level unless funded by the state. However, we recognize that there are many valuable and effective programs that provide critical services that supplement the programs described in this report.

The Hogg Foundation offers this guide to help policymakers in Texas understand the array of behavioral health services currently available, the multiple access portals and the numerous funding streams. We want to reiterate that this area of health care is extremely complex and constantly evolving. While the information in this report is the best available at the time, new innovations in health care, new legislation and new programs are continually changing the landscape of behavioral health care services in Texas. We hope that this report serves as a useful introduction and guidebook that illustrates the critical need for a long-term, coordinated, sufficiently funded approach to providing effective behavioral health care services.

Section 1. Introduction

The mental health of Texans has a direct impact on nearly every aspect of our quality of life, economic productivity, student school success, criminal justice, and public health and safety. Meeting the behavioral health care needs of Texans requires critical policy analysis and decision-making to ensure a coordinated system of supports and services that are effective, appropriate and fiscally responsible. The maze of behavioral health services in Texas is complex, making it difficult to understand and, consequently, difficult to improve.

Behavioral health is the term typically used when referring to mental health and substance use. The goal of behavioral health policy should be recovery. Recovery from mental illness and substance use is possible. Recovery is not synonymous with a cure, it is a process that enables individuals experiencing mental health challenges to become empowered to manage their illness and change their lives. Recovery, however, does not happen in isolation. Recovery requires support from peers, family, friends and the healthcare system, especially mental health professionals and supports provided by public mental health systems.

Although the road to recovery will look different for each individual, effective supports, interventions and treatments are widely recognized. While crisis intervention often relies heavily on the support of mental health professionals, long-term recovery focuses on personal responsibility, peer support and self-direction of services and treatment. Psychosocial supports such as assertive community treatment, peer support and Wellness and Recovery Action Planning (WRAP®) often provide long-term stabilization and increased quality of life beyond the short-term impact of medical interventions. Additional information is provided in Section 4. Public Behavioral Health Services in Texas.

Public behavioral health services in Texas are dispersed among many programs and agencies. Individuals needing treatment may receive care through a variety of state agencies including:

- Health and Human Services Commission
- Department of State Health Services
- Department of Family and Protective Services
- Department of Aging and Disability Services
- Department of Assistive and Rehabilitative Services
- Texas Department of Criminal Justice
- Texas Department of Juvenile Justice
- Texas Education Agency
- Texas Department of Housing and Community Affairs

Additionally, behavioral health services are provided at the local level in jails, hospital emergency rooms, schools, public health clinics and other settings, and people frequently bounce between service systems. For example, the Texas Public Policy Foundation has reported that 17% of the 1 million Texans jailed last year had previously received services through a local mental health authority.[1] A 2012 Travis County analysis[2] found:

Behavioral health is the term typically used when referring to mental health and substance use. The goal of behavioral health policy should be recovery.

"Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

Source: Substance Abuse and Mental Health Services Administration. (2011, December 22). SAMHSA announces a working definition of "recovery" from mental disorders and substance use disorders. Retrieved from www.samhsa.gov/newsroom/advisories/1112223420.aspx

Adults with multiple inpatient psychiatric hospitalizations had serious mental illness (major depressive disorder, bipolar disorder or schizophrenia), very high rates of co-occurring substance use, an average of 40 emergency department visits each, and much higher rates of homelessness.

Due to system fragmentation and the lack of data across state agencies, it is difficult to identify the total amount spent on behavioral health services in Texas. Data gathered across state agencies is not congruent and there is no ongoing mechanism to collect and analyze financial data solely related to behavioral health services. While the total cross-agency spending on behavioral health services is not clear, the Kaiser Family Foundation has determined that mental health spending per capita in Texas by the primary state mental health agency (the Department of State Health Services) is the lowest in the nation. The study found that annual per capita mental health spending in Texas is estimated at $38.38, while the national average is $122.90.[3]

This low level of spending and underfunding of preventive, community and crisis services creates higher costs in jails, prisons and hospitals and frequently leads to higher spending for other health conditions such as diabetes and heart disease. Chronic homelessness also is often the result of untreated mental illness, further adding to societal costs and creating additional challenges for both the individual and the community.

Failure to address the behavioral health needs of Texans is costly in terms of personal impact as well as economic consequences. The following statistics illustrate some of these costs:

- Adults with untreated mental health conditions are eight times more likely to be incarcerated.[4]
- Between 60 to 70% of individuals in contact with the juvenile justice system meet criteria for a mental health disorder. Sixty percent of these youth have a co-occurring substance use disorder.[5]
- For every dollar spent by federal and state governments on substance use, 95.6 cents covered costs to public programs outside of the behavioral health agency, such as criminal justice, and only 1.9 cents funded prevention and treatment programs.[6]
- One in five school-age children have a mental health condition and 5% have a mental health condition that results in significant functional impairment.[7]
- In 2007, one in eight or nearly 12 million emergency room visits were due to mental health and/or substance use conditions in adults.[8]

Insufficient access to mental health treatment, supports and services remains one of the most pressing policy issues in Texas. Many Texans are unable to obtain services due to lack of access to private or public insurance coverage and insufficient public mental health safety net services. Over time, these shortages have led to persons receiving services through a confusing, uncoordinated and inefficient system of state and local agencies, often resulting in poorer health outcomes at greater expense.

Fortunately, the current Texas policy environment offers new options for expanding and improving the delivery of behavioral health services in Texas, providing opportunities to develop a system that is less fragmented and more accessible to consumers of behavioral health services. The federal Patient Protection and Affordable Care Act (ACA), Texas Healthcare Transformation and Quality Improvement Program Medicaid 1115 Waiver, and a 2011 legislatively required analysis of the Department of State Health Services behavioral health system (Rider 71) could all lead to the development of a more comprehensive, integrated and coordinated approach to the delivery of behavioral health services. With multiple initiatives in play, the potential for improvement is significant.

Section 2. National Context

Policy decisions relating to behavioral health, made at the federal level, can have significant impact on programs and services in Texas. Currently, two major areas in particular provide the most potential for impacting Texas programs and policies. First, the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Patient Protection and Affordable Care Act (ACA) are influencing the design of health insurance benefits for both public and private health plans that insure the majority of Texans. The impact of these acts on behavioral health is discussed later in this section.

Second, a national movement is under way to transform behavioral health delivery systems. This federally supported initiative emphasizes recovery, wellness and self-directed care and encourages the use of innovative, evidence-based service delivery strategies, such as expanding the use of certified peer specialists and integrating physical and behavioral health care. This shift in treatment strategy, combined with the expanding role of affected individuals and their families in policy discussions and the decision-making process, offers a new approach to treatment that is designed to provide the right care at the right time and in the right setting.

Federal Health Care Legislation

The New Freedom Commission and Transformation of Behavioral Health Care

In 2002, President George W. Bush created the President's New Freedom Commission on Mental Health to study the mental health system and to identify goals and strategies that would significantly improve the lives of children and adults with serious behavioral health conditions. The New Freedom Commission's work built upon two previous influential national studies: the 1999 Mental Health: A Report of the Surgeon General and the Institute of Medicine's 2001 *Crossing the Quality Chasm: A New Health System for the 21st Century*.[9]

The New Freedom Commission's goals addressed a number of important issues, including:[10]

- An emerging systemic shift in behavioral health services toward recovery from mental illness.
- The benefits of providing opportunities to consumers and families for more self-directed care.
- The importance of peer-operated programs and services.
- The overall lack of access to behavioral services.
- The role of stigma as a barrier to seeking treatment.
- The need for housing and supported employment for persons with serious mental illness.
- The complexity of the public multi-agency safety net system and how that hinders access to services.
- The importance of screening and early intervention through integrated primary and behavioral health care approaches.

- The need to address racial, cultural and linguistic disparities in access to care.
- The increased use of technology, including telemedicine/telehealth and electronic health records, to increase access to services in rural and underserved areas and improve provider coordination.
- The need to more quickly move research-based interventions into common provider practice.

The New Freedom Commission's philosophy and strategies have positively influenced the priorities of federal agencies, especially the Substance Use and Mental Health Services Administration (SAMHSA) and state public mental health agencies. For example, SAMHSA released a series of competitive grant applications to support states in their efforts to re-engineer public behavioral health services. Texas received a state incentive grant for treatment of persons with co-occurring substance-related and mental health disorders, an access to recovery grant, and a mental health transformation incentive grant. Collaboration between the Department of State Health Services (then the Texas Department of Mental Health and Mental Retardation) stakeholders and the Texas Legislature's 2004 House Bill 2292 also led to the adoption of resiliency and disease management (RDM), or, "an effort to redesign the way public mental health services are delivered to adults with severe and persistent mental illness and children with severe emotional disturbance."[12]

Through these reform efforts, SAMHSA has strongly supported consumer and family support initiatives, the enhanced use of evidence-based interventions, the reduction of mental health disparities among ethnic and cultural groups, and other activities. SAMSHA also supports state and local efforts to change the philosophy and practice of child mental health planning and service delivery across child-serving agencies. For example, SAMHSA has awarded grants to develop a comprehensive strategic plan for improving and expanding services provided by systems of care for children and youth with serious mental health conditions and their families.

As described in Section 6. Best Practices and Policy Priorities, a "systems of care" is an organizational philosophy and framework that creates a network of effective community-based services and supports to improve the lives of children and youth with, or at risk of, serious mental health conditions and their families. Systems of care build meaningful partnerships with families and youth, address cultural and linguistic needs, and use evidence-based practices to help children, youth and families function better at home, in school, in the community and throughout life.[13] Additional information on federally supported efforts to transform behavioral health delivery in Texas is provided in Sections 4. Public Behavioral Health Services in Texas and 6. Best Practices and Policy Priorities.

Systems of care build meaningful partnerships with the families, youth and children being served.

Other federal agencies also have changed their practices to support these new approaches to behavioral health services. For example, the Center for Medicare and Medicaid Services (CMS) has approved the use of Medicaid for home and community-based services in place of institutional care for persons with mental illness. Additionally, the Health Resource and Services Administration (HRSA) released higher education grants to

encourage students to enter mental health and substance use fields. It is anticipated that SAMHSA will continue to promote the recovery approach to mental health services across federal agencies.

Mental Health Parity and Addiction Equity Act

In 2008, Congress enacted the Mental Health Parity and Addiction Equity Act (MHPAEA) to further expand the mental health parity requirements included in the 1996 Mental Health Parity Act. The MHPAEA also added coverage requirements for substance use services. In addition to the restriction on annual or lifetime limits enacted under the 1996 law, MHPAEA prohibits insurers or health plans that offer mental health services from imposing lower limits on the scope or duration of mental health services. This includes frequency of treatment, number of visits, days of coverage, or any other limits that are less than the limits imposed on coverage for medical or surgical services for physical health care. The MHPAEA also amended the definition of small employer to include firms with only one employee to provide consistency with state laws that include single-employee firms in their definition of small groups.[14]

These provisions apply only to group plans that offer behavioral health benefits. The MHPAEA does not require that behavioral health services be included in every group plan. However, the Affordable Care Act expands the parity law by requiring the inclusion of mental health and substance use services as essential health benefits in all group and individual health plans beginning January 2014. The level of required coverage will vary depending on the state's selection of a benchmark plan.

The Patient Protection and Affordable Care Act

The 2010 Patient Protection and Affordable Care Act (ACA) includes a number of provisions that have the potential to significantly improve access to both public and private mental health and substance use health care services. The law includes specific benefit requirements and more general insurance reforms that will affect all enrollees, not just those in need of behavioral health care.

A number of reforms are already applicable to most insurance plans as of 2012. As a result of these reforms, most plans:

- Prohibit lifetime limits and annual limits on covered health care services.
- Extend dependent coverage, allowing children to stay on a parent's policy until they reach the age of 26.
- Provide an appeals process for consumers.
- Provide coverage for any preexisting health conditions (including mental health or substance use) for enrollees under age 19 (with expansion to include adults in 2014).
- Prohibit rescinding coverage once a plan has been issued.

The ACA also includes insurance reforms that are particularly important for individuals with a history of mental health or substance use conditions. These provisions apply to individual and group plans beginning January 1, 2014 and will:

- Prohibit using health-status factors as a basis for eligibility for coverage or to deny coverage, including preexisting physical and mental illness, genetic information,

receipt of health care for a prior or current condition, disability, or any other health status factor.
- Require acceptance of any applicant regardless of age, gender or health status and prohibit cancellation or non-renewal except under limited circumstances (such as financial solvency issues or loss of the company's license).
- Require compliance with premium rating restrictions that allow limited variation of rates based on age, gender or tobacco use, but prohibit the use of health factors.
- Include comprehensive behavioral health services as required essential health benefits.

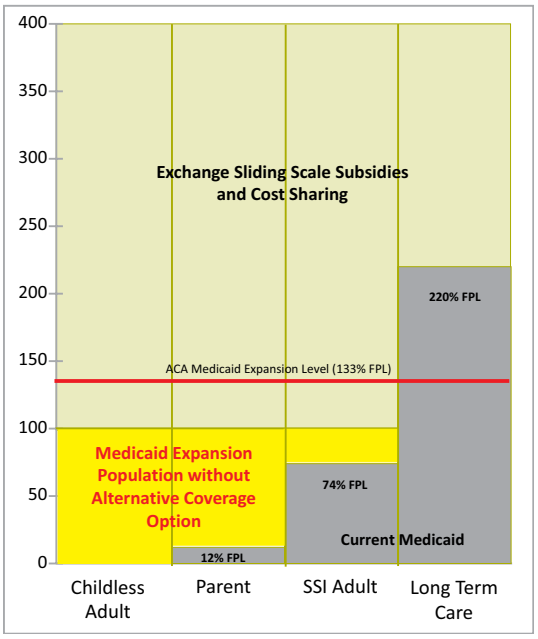
A fundamental provision of the ACA requires people to obtain insurance that meets "minimum essential coverage" requisites or pay a penalty for noncompliance. This is often referred to as the "individual mandate." Although a number of states challenged the constitutionality of the individual mandate, in June 2012 the Supreme Court upheld this provision of the law.[15] The law also requires every state to provide an insurance exchange (either federal or state-operated) through which people may purchase insurance that meets the federal standards. To assist people in meeting the individual mandate requirements, the law provides subsidies in the form of tax credits for certain individuals and families earning between 100% and 400% of the federal poverty level. The ACA does not extend the tax credits to individuals below 100% of the federal poverty level because the ACA expands Medicaid coverage to this population.

Medicaid Expansion

In addition to the individual mandate, the ACA requires states to expand Medicaid coverage to adults and children up to 133% of the federal poverty level. In Texas this expansion would primarily cover low-income adults generally not eligible for Medicaid unless they are receiving social security income (SSI) as a result of a disability. The Supreme Court's decision, however, prohibited the federal government from withholding Medicaid payments to states for non-compliance with the expansion provision. Consequently, states may choose whether or not to expand their Medicaid program. If a state chooses to expand coverage, the federal government pays 100% of the cost for the first three years starting in 2014 and no less than 90% of the cost in future years.

Following release of the Supreme Court decision, Governor Rick Perry announced that Texas would not participate in the Medicaid expansion. This decision will likely create a gap in coverage options for adults below 100% of the federal poverty level. Because Congress assumed that all U.S. citizens below 100% would be covered under the Medicaid expansion, the ACA does not provide tax credits for people below the poverty line (i.e., 100% of poverty). While many of these individuals will be exempt from the individual mandate based on their financial status, they are also likely to remain uninsured since they will not be eligible for Medicaid and will be unable to afford private coverage without the subsidy. In a presentation dated August 1, 2012, the Texas Health and Human Services Commission estimated that approximately 1.34 million uninsured adults would be eligible for the Medicaid expansion. However, without the expansion many are now likely to remain uninsured.

Figure 1. Texas Medicaid Expansion Population Based On Income and Federal Poverty Levels (FPL)



The chart to the left shows the group of uninsured low-income adults that would have no other coverage option in absence of the ACA Medicaid Expansion.

Note: The ACA expands Medicaid coverage for adults under 65 (up to 133% FPL). However, subsidies are available to adults through the Exchange beginning at 100% FPL.

Annual Income Levels

FPL Level	Individual	Family of 3
12%	$1,340	$2,291
74%	$8,266	$14,126
100%	**$11,170**	**$19,090**
133%	$14,856	$25,390
400%	$44,680	$76,360

Source: Suehs, T. (July 12, 2012). *Presentation to the House Appropriations Subcommittee on Article II: Affordable Care Act* [PDF document]. Retrieved from **www.hhsc.state.tx.us/news/presentations/2012/071212-ACA-Presentation.pdf**

Establishment of "Benchmark Plans"

The ACA requires states to identify a benchmark plan and defines 10 broad categories of essential health benefits that must be included in the plan. The required essential health benefits include mental health and substance use disorder services. Each state is directed to select a benchmark plan from delineated options while retaining some discretion on what specific services will be included in each essential benefit category. The federal government has identified 10 plans from which states may select their benchmark plan, including the following: the state's three largest small-group plans; three largest state employee health plans; three largest federal employee health plans; and the largest non-Medicaid health maintenance organization. If the benchmark plan selected by the state does not include all of the required essential health benefits, the state must supplement the missing benefits by using benefits from other benchmarks to fill in gaps in coverage. For example, if a benchmark plan does not cover maternity services, the state must select maternity benefits from another benchmark plan to supplement coverage in the state's selected plan.

Regardless of whether a state decides to set up its own exchange or participate in a federal exchange, the state will determine the benchmark plan and any required supplemental benefits. Selection of a benchmark plan and determination of essential health care benefits will strongly impact how insurers define "behavioral health services" and the specific services that will be available through the exchange.

Opportunities to Improve Access to Care

In addition to the mandated changes, the ACA offers a number of optional opportunities for states to improve care and increase access, including:

- A state option to develop health homes for persons with chronic conditions, including mental health and substance use conditions. This is an effort to better coordinate physical health and behavioral health services and community supports for persons with complex conditions. Community mental health centers may serve as health homes for persons with serious behavioral health conditions.[16]
- Demonstration projects to permit inpatient treatment in freestanding psychiatric hospitals of adults receiving Medicaid services. Currently, adults on Medicaid can receive services in general acute care hospitals but not free-standing psychiatric hospitals, due to the "institutions of mental disease" exclusion (see Section 4. Public Behavioral Health Services in Texas for information on this exclusion.
- Expanded options for home and community-based services under 1915(i) Medicaid provisions.[17]
- Medicare screening and preventive services, which may include mental health services.
- Closure of the "donut hole" for prescription drug benefits in the Medicare program (including psychotropic medications), generating significant cost savings for seniors.
- Support for behavioral health research and education such as grants to establish effective services for women with post-partum depression and centers of excellence for depression.

Expanding the Health Care Workforce

Finally, the ACA provides incentives to address the insufficient supply of professionals providing behavioral health services. These include increasing the number of primary care physicians (who provide a great deal of behavioral health care) and educating existing primary care staff about behavioral health care. Other provisions seek to increase the supply of behavioral health professionals through loan repayment and expanded residency training programs and increased use of certified peer specialists.[18]

Section 3. The Texas Environment

A primary barrier to effective and efficient services is the fragmentation of services and lack of coordination among multiple funding silos. Texas should carefully evaluate all of the opportunities to improve behavioral health services to ensure the development of a comprehensive and cohesive system. Toward this end, a number of major initiatives and reform efforts that could impact behavioral health service delivery and financing are being implemented or are currently under consideration. It is critical that these initiatives and opportunities are considered in the context of the entire state system and not in isolation.

Critical initiatives and opportunities should be considered for the entire behavioral health delivery system rather than in agency silos.

Potential Impact of the Affordable Care Act on Behavioral Health Services in Texas

Unknown at this time is how several major elements of the Affordable Care Act (ACA) will impact behavioral health financing and service delivery in Texas. These components include the health home state plan option for persons with complex conditions and the essential health benefits for both insurance health plans and the Medicaid expansion.

Health Homes

The ACA allows states to amend their Medicaid plans to provide care coordination services through health homes for beneficiaries with chronic conditions, including serious and persistent mental health conditions. The ACA also provides an opportunity for states to improve care by providing federal funding for certain Medicaid-covered health home services, including comprehensive care management, care coordination, health promotion, comprehensive transitional care, beneficiary and family support services, and referral to community and social support services.[19]

A Commonwealth Fund study found, even before Centers for Medicare and Medicaid Services (CMS) issued guidance, "the health home initiative attracted great interest across states, with the majority of state Medicaid directors indicating on a nationwide survey that they would likely establish health homes under this new authority."[20] One example of a state pursuing the health home option is Missouri. Missouri has been approved to establish health homes for persons with serious mental illness to reduce inpatient hospitalization and emergency room visits, increase primary care nurse liaison staff available at community mental health centers, add primary care physician consultation, and enhance the state's ability to provide transitional care between institutions and the community.[21]

By December 2010, at least 39 states had already implemented or planned medical homes for their Medicaid or Children's Health Insurance Program (CHIP) populations. At this time, Texas is not considering the health home option for persons with serious mental illness or serious emotional disturbance.[22]

Medicaid Expansion in Texas

One of the most significant provisions of the ACA would expand Medicaid to cover adults up to 133% of the federal poverty level. While Governor Rick Perry has announced that Texas will not participate in the expansion of Medicaid, the Texas Legislature is expected to revisit the issue in 2013. The Texas Health and Human Services Commission (HHSC) estimates that if the state moves forward with the Medicaid expansion, more than one million new adults would qualify for and enroll in Medicaid by 2015. With the expansion population and the availability of tax credits (subsidies) for low income people, HHSC estimates more than 2.65 million Texans would obtain new coverage and the number of uninsured would drop almost in half from 5.59 million to 2.9 million. Without the expansion, nearly one million Texans (of the 2.65 million) who could be covered through Medicaid will go without health care benefits leaving a total of approximately 3.88 million uninsured.

More information on the Affordable Care Act is available in Section 1. National Context.

Opportunities for Integrating Health Care

Children, adolescents and adults with mental health and substance use conditions are frequently treated in primary care settings. A 2001 national study found that of the 18% of adults who used mental health services that year, over half received treatment in a primary care setting.[23] Approximately 19% of all children seen in primary care are determined to have emotional and/or behavioral conditions.[24] About half of the care for common mental health conditions, including the prescribing and monitoring of psychotropic medication, is provided in primary care settings.[25] The integration of physical health and behavioral health services is an opportunity to more efficiently provide services and address health disparities.[26]

The ACA encourages the creation of accountable care organizations (ACOs) and the use of health homes, both of which support integration of behavioral health care in a coordinated, evidence-based system of care. The requirement to provide essentially equal levels of insurance coverage for behavioral health services also will serve as an incentive for primary care providers to coordinate services with mental health and substance use providers. The law also includes provider payment reforms that will shift payments from a fee-for-service model to new arrangements that reward health outcomes and prevent hospitalizations.

Behavioral Health Implications of New Health and Human Services Initiatives

Texas Health Care Transformation and Quality Improvement Program

The Texas Health Care Transformation and Quality Improvement Program (authorized under a federal 1115 transformation waiver) allows the state to expand Medicaid managed care while preserving federal hospital funding previously received as upper payment limit (UPL) payments—supplemental payments to make up the difference between what Medicaid paid for a service and what Medicare would pay for the same service.

Under the 1115 transformation waiver, two funding pools are replacing the UPL payment methodology. Payments from the Uncompensated Care Pool will help offset the costs to hospitals for treating people who are uninsured and have no other means of payment. Payments from the Delivery System Reform Incentive Pool (DSRIP) will provide incentives for hospitals and other providers to develop programs or strategies that enhance access to health care, quality of care, and cost-effectiveness. Performance metrics, milestones and improved outcomes are required components of the 1115 waiver. Payments will be based on performance outcomes and not simply on delivering a service.

Under the 1115 transformation waiver, eligibility for DSRIP payments requires participation in a regional health care partnership (RHP). Texas has designated 20 RHPs and has identified an "anchor entity" for each. Anchor entities coordinate efforts to develop and implement regional plans, but do not control the partnership funding. Each partnership is comprised of participating entities that can provide public funds known as intergovernmental transfers (IGT). Local mental health authorities may use state general revenue funding as IGT and will be eligible for the DSRIP federal funding. This has the potential to substantially increase funding for community behavioral health services.

The 1115 transformation waiver provides an opportunity to expand behavioral health services through DSRIP payments to local mental health authorities or other entities implementing projects to expand or enhance behavioral health care. Examples of potential projects include increasing access to community clinics with extended hours of operation, expanding the behavioral health workforce, integrating physical and behavioral health services, and creating crisis stabilization units. RHP plans must be submitted to the CMS and implementation can begin upon federal approval of the plans, which is expected no later than early 2013.

1915(i) State Plan Amendment

A Medicaid 1915(i) Home and Community-Based Services (HCS) waiver allows states to focus on populations with complex needs without requiring that the person be eligible for an institutional level of care to qualify. The waiver allows states to provide services and supports that are necessary to keep people in the community.

Texas is considering the potential of a 1915(i) Medicaid state plan amendment to help finance home and community-based services for people with serious mental illness especially those residing in state psychiatric inpatient facilities for extended periods and for those who have frequent readmissions. This waiver would provide opportunities for coordinating stable housing and ongoing services to reduce the frequency and high cost of hospitalization.

This option would require state and federal approval as well as an additional appropriation of state funds as a match for federal Medicaid dollars. The Department of State Health Services (DSHS) included a funding request for a 1915(i) waiver as an exceptional item in the department's 2014-2015 legislative appropriations request (LAR).

Community First Choice Medicaid State Plan Option

The passage of the ACA provides a new optional Medicaid program to assist persons with disabilities to live in the community rather than in institutional settings. Section 1915(k), Community First Choice, was added to Medicaid as an optional service and would allow limited community services and supports such as attendant care to be

offered under the Medicaid state plan. These services are currently offered to individuals with physical or medical disabilities through the Primary Home Care program, but are not offered to individuals with intellectual and developmental disabilities or mental health conditions. Should Texas elect to implement Community First Choice, home and community-based services and supports could facilitate successful community living for thousands of Texas adults.

1915(b) Selective Contracting for Rehabilitation Services

The Texas Health and Human Services Commission (HHSC) submitted to CMS a request for a waiver that would allow the state to contract solely with local mental health authorities to provide vital Medicaid rehabilitation services for persons with mental illness. Approval of this waiver would prevent other providers from contracting directly with DSHS to provide rehabilitation and targeted case management services, limiting consumers' choice of provider. HHSC has placed a hold on this waiver request and as of October 2012, next steps are still pending.[27]

1115 Medicaid Reform Waiver for Long-Term Services and Supports

In a February 2012 presentation to the SB 7 Medicaid Reform Waiver Legislative Oversight Committee, HHSC presented a Medicaid long-term services and supports (LTSS) framework for reform. The framework includes:

1. Potential reforms to long-term services and supports systems, including community-based waiver programs.
2. Balancing incentives payment (BIP) program initiatives.
3. Shared savings option to integrate care for individuals dually eligible for Medicare and Medicaid.
4. Community First Choice option.
5. Additional potential reforms outlined in SB 7 (82nd).[28]

A copy of SB 7 can be found at: **www.capitol.state.tx.us/BillLookup/History.aspx?LegSess=821&Bill=SB7**.

Although the financing opportunities for these reform initiatives were unknown at the time of the presentation, HHSC assumed "additional reforms would be accomplished through a federal 1115 waiver." HHSC offered the following possible options to further improve quality, access and cost effectiveness for the delivery of LTSS:

- Quality-based payments and programs for nursing facilities.
- Enrollment of persons with intellectual and developmental disabilities in managed care for acute care services.[29]

Independent Study of the Department of State Health Services Public Behavioral Health System

Rider 71 to House Bill 1, 82nd Texas Legislature, required a comprehensive analysis of the behavioral health services funded or managed by DSHS and HHSC. The review included mental health and substance use services managed through local mental health authorities and NorthSTAR (the state's only Medicaid managed care program for behavioral health services), state psychiatric hospitals, Medicaid and CHIP. The Phase I analysis of the

system was released in June 2012 and is available at **www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf**.

Final recommendations developed as a result of the study and released on October 12, 2012 are expected to be considered by the 83rd Texas Legislature beginning in January 2013. If enacted, many of the recommendations could result in major changes to public behavioral health services.

Behavioral Health Workforce Shortages

One of the most severe health care provider workforce shortages in Texas is that of behavioral health professionals. Texas ranks below the national average in the number of mental health professionals per capita, a trend that is likely to continue given a growing state population and the retirement of aging professionals.[30] A 2012 study found that 31.1% of Texans live in a federally designated Health Professional Shortage Area for mental health.[31] A total of 173 out of 254 Texas counties have been designated by the federal government as having a shortage of mental health professionals such as social workers, counselors, psychologists and psychiatrists.[32]

While the supply of mental health professionals in Texas is declining, the demand for behavioral health services continues to grow. The state is attempting to address the shortage through a number of initiatives, including:

1. Expansion of the use of certified peer specialists.
2. Creation and expansion of telemedicine and telehealth programs.
3. Expansion of workforce training and education programs.
4. Adoption of strategies to attract and retain more providers.

A more detailed discussion of mental health workforce shortages in Texas and alternatives for addressing the problem is in Section 7. Mental Health Workforce Shortages.

Texas Mental Health Code Update

The Texas Mental Health Code (Subtitle C of the Texas Health and Safety Code) has not been substantially revised since 1985. It is considered outdated and confusing by many mental health consumers and families, lawyers, judges, law enforcement personnel and advocates.

With funding from the Hogg Foundation for Mental Health, Texas Appleseed and Disability Rights Texas led a statewide process to solicit input on needed changes. A series of community public hearings was held in 2011 to gather comments and recommendations. A steering committee composed of leading judges, law professors, attorneys, advocates, consumers and clinicians considered this information and recommended that the Texas Legislature repeal the majority of the current mental health code and replace it with new language as suggested in the draft report. The committee also recommended that the code be reorganized and reflect current approaches to consumer rights and evidence-based practices. Specific recommendations for changes to the code address a variety of key issues, such as voluntary admissions, emergency detention and court-ordered treatment. The report, *Recommendations for Updating the Texas Mental Health Code: A Response to Decades of Dramatic Change in Texas' Mental Health System,* is available at: **www.texasappleseed.net/index.php?option=com_content&view=article&id=130&Itemid=279**.

State Hospital Privatization

Rider 63 to House Bill 1, 82nd Texas Legislature, required DSHS to solicit bids to privatize a state psychiatric hospital. According to the rider, if awarded, the contract must generate 10% annual savings with the actual savings based on the FY 2010 funding level. These savings must be projected for at least four years. Other requirements were:

- The hospital must continue to serve the same populations currently served.
- The hospital must maintain national accreditation by The Joint Commission (formerly the Joint Commission for Accreditation and Standards).
- The state retains ownership of the hospital property.

A request for proposals (RFP) was released in April 2012. Only one entity submitted a proposal, which DSHS rejected.

Forensic Restoration of Competency Lawsuit

Competency restoration in the criminal justice system is the process used when people with mental illness or intellectual disabilities are charged with crimes but are deemed incompetent to stand trial. Before the legal process can continue the person must be restored to competency and be able to participate in his or her defense. Competency restoration generally takes place in state psychiatric hospitals, although in recent years local mental health authorities and the legislature have made a significant commitment to providing competency restoration services in the community.

The number of inpatient forensic commitments has grown dramatically in recent years, but the number of available beds in state hospitals has not increased. Consequently, defendants are often held in local jails for an extended period, sometimes longer than the maximum sentence for the crime charged, until a hospital bed is available. For the past five years, defendants with mental illness have spent an average of 41 days in local jails, untreated and unable to go to court while waiting for a forensic bed at a state hospital.[33] Meanwhile, increasing demand for forensic beds at state-operated psychiatric hospitals continues to reduce the number of beds available for civil commitments. Currently, of the 2,963 inpatient beds available, 1,851 are used for civil inpatient care, 746 for forensic non-maximum security care and 366 for forensic maximum-security care.[34]

The Sixth Amendment to the U.S. Constitution requires "that in all criminal prosecutions, the accused shall enjoy the right to a speedy trial." In 2011, the 82nd Texas Legislature enacted house bills 748 and 2725, limiting incarceration time while waiting for competency restoration to periods no longer than the maximum penalty for the crime charged.

In January 2012, a Travis County District Court judge ruled on a forensic restoration capacity lawsuit filed in 2007. The ruling stated that a defendant deemed incompetent to stand trial cannot be held in jail more than 21 days before admission to a competency restoration program.[35] DSHS is opening new forensic beds at current state hospitals and contracting for civil beds in local communities in an attempt to meet this demand.[36] Additionally, the state has expanded the number of outpatient competency restoration sites to reduce the number of people waiting for inpatient services. More information on Texas outpatient competency restoration services is provided in Section 6. Best Practices and Policy Priorities.

Section 4. Public Behavioral Health Services in Texas

A 2003 report by the President's New Freedom Commission on Mental Health characterized mental health systems across the nation as follows:

> *"The mental health system is fragmented and in disarray not from lack of commitment and skill of those who deliver care, but from underlying structural, financing and organizational problems. Many of the problems are due to the 'layering on' of multiple, well-intentioned programs without overall direction, coordination or consistency."*[37]

A decade later, this description still aptly captures the status of the behavioral health system in Texas. Despite good intentions, program revisions have often occurred with little attention to long-term planning and in the absence of a strategy for developing a coordinated system of care. Depending on the fiscal status of the state, legislators may reduce funding and programs for behavioral health services in one biennium, only to reverse their decisions when the budget improves. While these budget decisions are understandable, the ongoing changes in programs and funding mechanisms have contributed to the development of a complex, often illogical infrastructure of behavioral health care services that fall under the oversight of multiple state agencies.

Behavioral health services and funding can be provided by any one of the following agencies:

- Health and Human Services Commission (HHSC)
  - Department of State Health Services (DSHS)
  - Department of Family and Protective Services (DFPS)
  - Department of Aging and Disability Services (DADS)
  - Department of Assistive and Rehabilitative Services (DARS)
- Texas Department of Criminal Justice (TDCJ)
- Texas Juvenile Justice Department (TJJD)
- Texas Education Agency (TEA)
- Texas Department of Housing and Community Affairs (TDHCA)
- Texas Veterans Commission (TVC)

With services dispersed across so many agencies, even the most sophisticated providers, consumers and family members encounter problems navigating this often cumbersome, complex maze of services that are often inadequate to meet the demand for care. This lack of coordination not only creates confusion but also reduces the cost-effectiveness of the limited funds available to provide critical care.

The Kaiser Family Foundation ranked Texas 51st in the nation in per capita spending by a state mental health agency.[38] The state's annual spending for mental health services equals $38 per capita—just 30% of the national average of $123 per capita (Figure 2).

Figure 2. Per Capita Behavioral Health Expenditures for the U.S. and Select State Mental Health Agencies (2009)

	Population	Per Capita Expenditure	Total Budget	Rank
United States	305,191,100	$123	$37,581,700,000	
Texas	24,840,100	$38	$946,600,000	51
Florida	18,413,600	$41	$755,300,000	50
Mississippi	2,877,500	$109	$319,900,000	26
California	36,899,700	$158	$5,801,000,000	15
New York	19,221,100	$242	$4,715,400,000	5

Sources: Kaiser Family Foundation. (n.d.). State Mental Health Agency (SMHA), per capita mental health services expenditures, FY 2009. Retrieved from **www.statehealthfacts.org/comparemaptable.jsp?yr=90&typ=4&ind=278&cat=5&sub=149&sortc=1&o=a;** National Association of State Mental Health Program Directors Research Institute, Inc. (2011). State Mental Health Authority mental health actual dollar and per capita expenditures by state, FY 2009 (using state civilian population) [Data file]. Retrieved from **www.nri-inc.org/projects/Profiles/RevExp2009/T1.pdf**

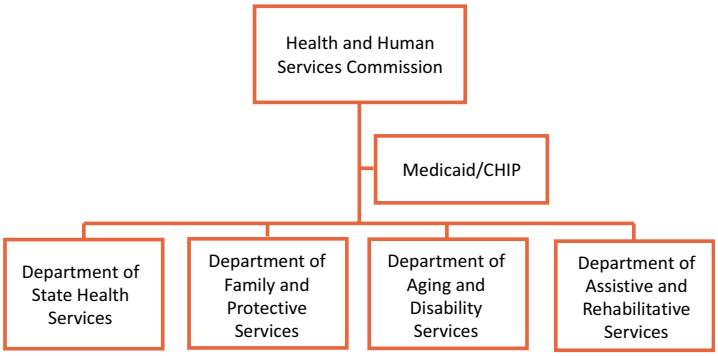
Failure to adequately fund behavioral health services results in substantial economic and societal costs. In 2008, The *American Journal of Psychiatry* reported that the annual cost of lost productivity in the U.S. due to mental illness was estimated at $193.2 billion.[39] The human toll is impossible to measure, but the consequences of limited funding and access to community and preventive mental health services means that individuals with behavioral health needs are inadequately served in jails, hospital emergency departments, adult and juvenile criminal justice agencies, schools, child protective services and other social service settings where services are often more costly and less effective.

Texas Health and Human Services Commission

The Texas Health and Human Services Commission (HHSC) is the umbrella agency overseeing Medicaid, the Children's Health Insurance Program (CHIP) and the operation of four major departments:

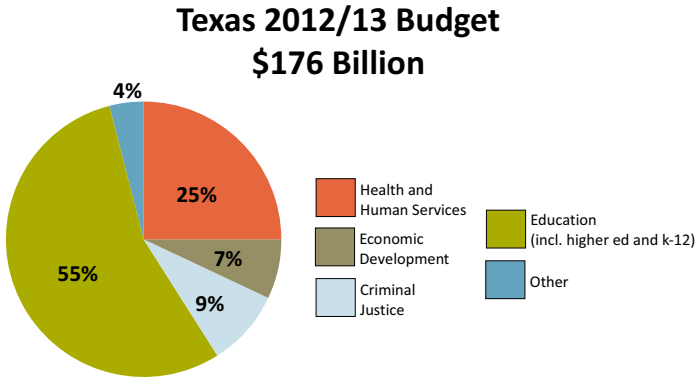
- Department of State Health Services (DSHS)
- Department of Family and Protective Services (DFPS)
- Department of Aging and Disability Services (DADS)
- Department of Assistive and Rehabilitative Services (DARS)

Figure 3. Health and Human Services Enterprise



HHSC and the departments under it are sometimes referred to as the health and human services "enterprise." The enterprise employs approximately 56,900 full-time equivalents[40] and provides services to more than 3.4 million Texans annually. The HHSC budget comprises approximately 25% of the entire state budget of $176 billion for the 2012-2013 biennium, as depicted in Figure 4.

Figure 4. Texas FY 2012 - 2013 Budget



82nd Texas Legislature. (2011). General Appropriations Act for the 2012-2013 biennium. Retrieved from www.lbb.state.tx.us/Bill_82/GAA.pdf

Policy Concerns:

- Funding for behavioral health services across agencies
- Coordination of services across agencies
- Adequacy of reimbursement rates for behavioral health services
- 1115 Transformation waiver
- Implementation of the Affordable Care Act
- Medicaid Reform for long-term services and supports

Medicaid Behavioral Health Services

Nationally, Medicaid is rapidly becoming the largest source of funding of public mental health services for children, youth and adults living with mental illness or serious emotional disturbance. In FY 2009, 48% of states' mental health funding came from Medicaid. In contrast, 16% of Texas' mental health funding came from Medicaid.[41] In

Texas, the Medicaid state plan services are overseen by HHSC. Medicaid behavioral health services, however, are also delivered to eligible individuals through other health and human services departments, particularly DSHS as described earlier.

Eligibility for Medicaid Behavioral Health Services

The Texas Medicaid program currently serves approximately 3.4 million people each month. In determining program eligibility, Texas considers a variety of factors such as income and family size, age, disability, pregnancy, citizenship and state residency requirements. Medicaid covers families with children and pregnant women, individuals who are medically needy, the elderly and people with disabilities.

The income eligibility requirements for each Medicaid category are based on the age of the individual and other key characteristics:

- Children age 1 to 5 – income up to 133% of the federal poverty level.
- Children age 6 to 18 – income up to 100% of the federal poverty level.
- Pregnant women and newborns – income up to 185% of the federal poverty level.
- Social security income recipients, aged and individuals with a disability – income up to approximately 74% of the federal poverty level.

To be eligible for Medicaid, an individual must meet state residency and categorical requirements. There are over 30 different Medicaid eligibility categories in Texas. Some of the primary categories include:

- Individuals/families receiving temporary assistance for needy families (TANF).
- Individuals receiving social security income.
- Pregnant women with infants and children.
- Older adults and people with disabilities.
- Individuals who are medically needy.
- Individuals dually eligible for Medicare and Medicaid.
- Certain working individuals with disabilities.

Currently in Texas, childless adults are not eligible for Medicaid at any income level. Parents are eligible only if income is below 12% of the federal poverty level ($2,291 annual income for a family of 3). People with disabilities receiving Social Security Income (SSI) are only eligible if income does not exceed 74% of the federal poverty level ($8,266 annual income for an individual).

Eligible Medicaid recipients, including adults and children, have access to mental health and substance use services included in the Medicaid State Plan, such as psychiatric services, counseling, and medication and medication management. A comprehensive description of the covered behavioral health services is provided in Figures 5 and 6.

Medicaid also funds mental health safety net services provided through DSHS and local mental health authorities. These services are described in the DSHS section.

Medicaid Funding for Mental Health and Substance Use State Plan and Safety-Net Services

Medicaid provides matching funds for behavioral health services through the Medicaid state plan. These are services accessed through the acute Medicaid program, including managed care and fee-for-service arrangements. Federal Medicaid matching funds also contribute to the funding of rehabilitative services, targeted

case management and other community safety net services for eligible individuals. These services are discussed in the DSHS section of this report. Medicaid-funded mental health services are shown in Figure 5. Medicaid state plan substance use services are described in Figure 6.

Figure 5. Medicaid Mental Health Services by Provider Type and Oversight Agency

Services	Provider(s)	Oversight Agency
Rehabilitation Services Day program for acute needs Medication training and support Crisis intervention services Skills training and development Psychosocial rehabilitative services	Local Mental Health Authorities and NorthSTAR	Department of State Health Services
Targeted Case Management		
Screening		
Assessment		
Assertive Community Treatment		
Supported Employment		
Supported Housing		
Physician Services	Enrolled Medicaid Providers and Managed Care Organization Contracted Providers	Health and Human Services Commission
Psychologist and LPC Services		
Electroconvulsive Therapy (ECT)		
Pharmacological Regimen Oversight and Pharmacological Management Services		
Psychiatric Diagnostic Interviews		
Psychological and Neuropsychological Testing		
Psychotherapy/Counseling		
Narcosynthesis		
Inpatient (Acute)		
Inpatient (State Hospitals)		
Crisis Services		

Source: Texas Health and Human Services Commission & Texas Department of State Health Services. (June 2012). Analysis of the Texas public behavioral health system. Retrieved from **www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf**

Figure 6. Medicaid Substance Use Services by Provider Type and Oversight Agency

Medicaid Population				
Services	**Provider(s)**	**Oversight Agency**	**Service Available to Adults**	**Service Available to Youths**
Screening	Enrolled Medicaid Providers and Managed Care Organization Contracted Providers	Health and Human Services Commission	X	X
Assessment			X	X
Residential Intensive			X	X
Residential Supportive			X	X
Inpatient Detox (in acute care hospital)			X	
Residential Detox			X	
Ambulatory Detox			X	
Outpatient Services			X	X
Individual			X	X
Group			X	X
Medicaid Assisted Therapy (MAT)			X	X
HIV Residential Wraparound Services	DSHS Contracted Providers	DSHS	X	
Youth Female Intensive Residential Wraparound Services – Room & Board				X
Youth Intensive Residential Wraparound Services – Room & Board				X
Adult Specialized Female with Child Residential Wraparound Services – Under 21			X	
Adult Specialized Female with Child Residential Wraparound Services – 21 and Over			X	

Source: Texas Health and Human Services Commission & Texas Department of State Health Services. (June 2012). Analysis of the Texas public behavioral health system. Retrieved from www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf

Federally Qualified Health Centers

Many of the services listed above are provided by federally qualified health centers (FQHCs), which are health care entities that receive grants through Section 330 of the Public Health Services Act. FQHCs play an important role in providing comprehensive health care services for people with public health insurance such as Medicaid, or who are otherwise low-income and uninsured or underinsured. There are 69 FQHCs in Texas with more than 300 sites delivering services.[42] In 2010, these sites served 948,685 individuals.[43]

While FQHCs receive funding directly from the federal government, they also receive payments for providing services to individuals receiving Medicaid and Medicare services. Increasingly, FQHCs are transforming their practices to health homes or comprehensive

medical homes to improve the coordination and integration of care for clients with multiple chronic conditions, including behavioral health and substance use.

Medicaid Buy-In Programs (Adults and Children)

Texas offers two Medicaid buy-in programs. Medicaid buy-in programs allow adults and children with disabilities to enroll in Medicaid when their income levels exceed normal eligibility limits. Participants must meet certain income criteria and may be required to pay a monthly premium. The health care services provided are the same as in the traditional Medicaid program. The Texas Medicaid buy-in program for adults is available to persons with a disability who are working and who do not live in a state institution or nursing home. The Texas Medicaid buy-in for children is available to families who have a child with a disability who is age 18 or younger, a U.S. citizen or legal resident, and not married. Most families are required to pay monthly premiums, co-pays or deductibles. Cost-sharing is based on income, the number of people in the family, and access to employer-provided insurance or the Medicaid Health Insurance Premium Payment Program (HIPP).

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) was created in 1997 under Title XXI of the Social Security Act. Like Medicaid, CHIP is jointly funded by the state and federal governments. Participation in CHIP requires approval of a CHIP plan by the Centers for Medicare and Medicaid Services (CMS). While CMS allows states to combine both the Medicaid and CHIP programs, Texas currently administers these programs separately.

Eligibility for CHIP

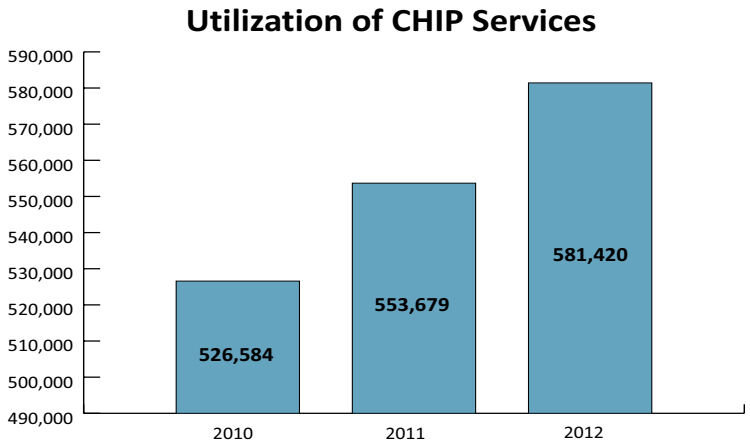
CHIP is available for Texas families making less than 200% of the federal poverty level so that low-income children can have access to health care, including inpatient and outpatient mental health and substance use services. CHIP was developed to provide health insurance coverage for children whose families had too much income or assets for Medicaid, but not enough to access individual or family insurance through employment or on their own. CHIP requires cost-sharing with enrollment fees and co-payments based on family income.

Enrollment, Utilization and Costs

Monthly enrollment levels in CHIP have increased steadily over the last three years to more than 580,000 members per month (Figure 7). The most current enrollment figure from September 2012 finds 580,453 children enrolled in CHIP.[44] CHIP spending has experienced sporadic growth in recent years and the cost of services is projected to increase to a level of $1.2 billion in 2013 (Figure 8).

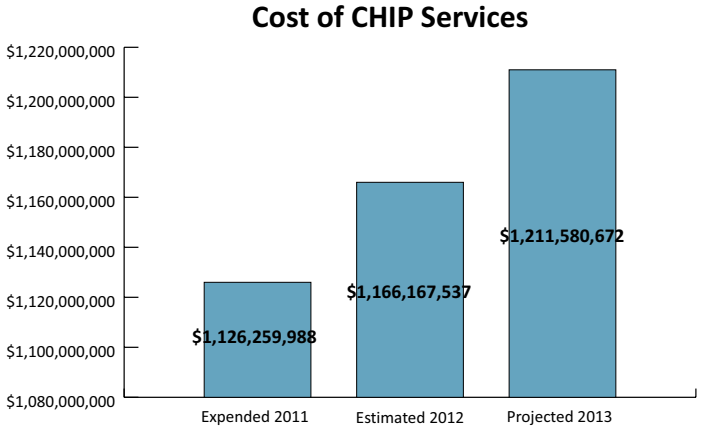
It is estimated that 80% of the CHIP budget is spent on inpatient, outpatient hospital services and physician services; 15% on prescription drugs; and the remaining 5% on administration.[45]

Figure 7. Utilization of CHIP Services



Note: Data is from October of every year. Source: Texas Health and Human Services Commission. (2012). CHIP enrollment, renewal and disenrollment by month. Retrieved from **www.hhsc.state.tx.us/research/CHIP/Disenrollment-Rate.asp**

Figure 8. Cost of CHIP Services



Source: Texas Health and Human Services Commission. (2012, August 23). *2A. Summary of base request by strategy – 83rd Regular Session, agency submission, version 1* [Data file]. Retrieved from **www.hhsc.state.tx.us/LAR/2014-2015/Summary-Base-Request-By-Strategy.pdf**

Behavioral Health Quality of Care Measures for Medicaid and CHIP

Texas contracts with the Florida Institute for Child Health Policy to perform the external quality review for the Texas Medicaid Managed Care STAR, STAR+PLUS, NorthSTAR, STAR Health and CHIP programs. Outcomes are compared to national Healthcare Effectiveness Data and Information Set (HEDIS) standards, when available, or to benchmarks that HHSC establishes. The national HEDIS standards are used across the country to measure performance in important areas of health care, including behavioral health services.

Statistics for selected Medicaid and CHIP behavioral health quality of care measures are presented in Figure 9 and selected behavioral health performance measures are shown in Figure 10.

Figure 9. Selected Behavioral Health Quality of Care Measures for Medicaid and CHIP

Program	Measure	Performance		
		2008	2009	2010
STAR	After dispensing new medication to treat ADHD had a follow-up visit within 30 days (Initiation Phase)	Not measured	Not available	47%
	After continuously taking medication to treat ADHD had at least two additional follow-up visits within 9 months (Continuation Phase)	Not measured in FY 2008	Not available	58%
	Follow-up care after hospitalization for mental illness within 7 days	37%	40%	45%
	Follow-up care after hospitalization for mental illness within 30 days	65%	68%	72%
	Readmission within 30 days - Adults	21% (all ages)	21% (all ages)	13%
	Readmission within 30 days - Children/ Adolescents	Not available separately	Not available separately	10%
STAR+PLUS	Antidepressant medication management within 3 months (follow-up visit after dispensed)	Not measured	Not available	50%
	Antidepressant medication management within 6 months (follow-up visit after dispensed)	Not measured	Not available	36%
	Follow-up care after hospitalization for mental illness within 7 days	34%	40%	46%
	Follow-up care after hospitalization for mental illness within 30 days	64%	67%	72%
	Readmission within 30 days - Adults	23% (all ages)	24% (all ages)	25%
	Readmission within 30 days - Children/ Adolescents	Not available separately	Not available separately	19%
STAR Health	After dispensed new medication to treat ADHD had a follow-up visit within 30 days (Initiation Phase)	Not measured	83%	89%
	After continuously taking medication to treat ADHD had at least two additional follow-up visits within 9 months (Continuation Phase)	Not measured	91%	94%
	Follow-up care after hospitalization for mental illness within 7 days	52%	61%	70%
	Follow-up care after hospitalization for mental illness within 30 days	83%	88%	92%
	Readmission within 30 days - Adults (represents only 5% of STAR Health population)	32%	28%	28%

Sources: Institute for Child Health Policy at the University of Florida. (August 30, 2011). Texas Medicaid Managed Care and STAR Program, EQRO quality of care report - FY 2010. Retrieved from **www.hhsc.state.tx.us/reports/2012/Care-Report-STAR-FY 2010.pdf**; Institute for Child Health Policy at the University of Florida. (November 30, 2009). Texas Medicaid Managed Care STAR Quality of Care Measure – Annual chart book, FY 2008. Retrieved from **www.hhsc.state.tx.us/reports/2010/CareReportSTAR_FY08_0310.pdf;** Institute for Child Health Policy at the University of Florida. (2009, September 24). Texas Medicaid Managed Care STAR+PLUS Quality of Care Measures – Annual chart book, FY 2008. Retrieved from **www.hhsc.state.tx.us/reports/2010/Annual_Quality_Care_FY08.pdf**; Institute for Child Health Policy at the University of Florida. (January 2, 2012). Texas Medicaid Managed Care and STAR+PLUS, EQRO quality of care report – FY 2010. Retrieved from **www.hhsc.state.tx.us/reports/2012/ann-qual-care-rep-STAR+PLUS-fy2010.pdf**; Institute for Child Health Policy at the University of Florida. (September 26, 2011). Texas Medicaid STAR Health Program, EQRO quality of care report, FY 2010. Retrieved from **www.hhsc.state.tx.us/reports/2012/ann-qual-care-rep-STAR-fy2010.pdf**; and Institute for Child Health Policy at the University of Florida. (November 30, 2009). Texas Medicaid Managed Care STAR Health Quality of Care Measures – Annual chart book, FY 2008. Retrieved from **www.hhsc.state.tx.us/reports/2010/Quality_Care_ReportFY08.pdf**

Figure 10. Selected Behavioral Health Performance Measures and Benchmarks for Medicaid and CHIP

Program	Measure	Performance FY 2010	Benchmark
Medicaid	Percentage of children with attention deficit hyperactivity disorder (the most common child diagnosis) who had an initial follow-up visit after being dispensed ADHD medication	47%	37%
	Percentage among STAR recipients hospitalized for mental illness who had a follow-up visit within seven days of discharge from the hospital	45%	32%
	Percentage among STAR recipients hospitalized for mental illness who had a follow-up visit within 30 days of discharge from the hospital	72%	52%
Medicaid	Percentage of recipients diagnosed with a new episode of major depression and treated with antidepressant medication who used the medication for at least three months	50%	50%
	Percentage of recipients diagnosed with a new episode of major depression and treated with antidepressant medication who used the medication for at least six months	36%	33%
	Percentage of recipients hospitalized for a mental health condition who had a follow-up visit within seven days of discharge	46%	32%
	Percentage of recipients hospitalized for a mental health condition who had a follow-up visit within 30 days of discharge	72%	52%
CHIP	Percentage of children with ADHD who had a follow-up visit within 30 days after being dispensed an ADHD medication	45%	37%
	Percentage of children who had an inpatient psychiatric hospitalization and had a follow-up visit within seven days of discharge	45%	32%
	Percentage children who had an inpatient psychiatric hospitalization and had a follow-up visit within 30 days of discharge	74%	52%

Source: Institute for Child Health Policy at the University of Florida. (August 30, 2011). Texas Medicaid Managed Care and STAR Program, EQRO quality of care report - FY 2010. Retrieved from **www.hhsc.state.tx.us/reports/2012/Care-Report-STAR-FY2010.pdf**

HHSC Mental Health Improvement Initiatives

HHSC has established a number of initiatives in recent years to improve the quality of and access to mental health services. A number of these efforts have focused on children, including those with special health care needs, as well as adults with disabilities. As the state's population becomes more racially and ethnically diverse, HHSC also has adopted initiatives to reduce disparities in health and mental health care.

Transforming the Child Mental Health System

As described below, HHSC facilitates a number of interagency efforts to improve child and family mental health care across its health and human services departments. These efforts include the System of Care for Child and Family Mental Health and four legislatively mandated committees under the Office of Coordination of Services for Children and Youth.

System of Care for Child and Family Mental Health

The system of care initiative is a national strategy that was developed in the 1980s to better plan and deliver services to families and their children with serious behavioral health challenges. System of Care is a framework and philosophy that addresses primary values by being:

- Family-driven and youth-guided.
- Community-based.
- Culturally and linguistically competent.

Information on the values and guiding principles of a system of care can be found at **www.tapartnership.org/SOC/SOCvalues.php**.

In Texas, the Integrated Funding Initiative (TIFI) was established by the legislature in 1999 as a means of implementing this philosophy of service through local pilot service integration programs. More recently, HHSC received a federal grant to support a statewide expansion of the system of care approach called the Achieving Successful Systems Enriching Texas Initiative (ASSET). ASSET is a joint project of HHSC, DSHS and the University of Texas Center for Social Work Research.

Further information on the Texas System of Care initiative is available at **www.txsystemofcare.org/about-us and www.hhsc.state.tx.us/tifi/TIFI_SystemCare.html**. ASSET is also discussed in Section 6: Best Practices and Policy Priorities.

Office of Coordination of Services for Children and Youth

Under the oversight of the Office of Coordination of Services for Children and Youth, four committees have been established to further improve the mental health system for Texas children through better coordination. They are:

- Community Resource Coordination Groups
- Children's Policy Council
- Texas Council on Children and Families
- Task Force for Children with Special Needs

Community Resources Coordination Groups

Community Resource Coordination Groups (CRCGs), established by the legislature in the late 1980s, are local interagency committees composed of public and private providers that coordinate services for children, youth and adults with complex service needs. A CRCG is located in each of the state's 254 counties. A CRCG's primary role is to work in partnership with referred individuals and their families to develop a strengths-based individual service plan (ISP) in which an agreement is reached on the coordination of services. Whenever possible, the ISP calls for services to be delivered in the community.

If this is not feasible, services are provided in the least restrictive environment outside of the community. In this situation, a community reintegration plan is included in the ISP. Involved service agencies are expected to exercise maximum flexibility, within existing eligibility criteria and funding policy, to meet the needs of individuals referred to the CRCG.[46] Funding to support CRCGs was eliminated by appropriations negotiations that took place during the 82nd legislative session in 2011.

Children's Policy Council

The Children's Policy Council was established by the Texas Legislature in 2001 to assist state health and human services departments in the development, implementation and administration of family support policies and related long-term care and health programs for children.

In its advisory role, the council studies and makes recommendations on the following issues:

- Access to case management services.
- Transition needs of children who reach an age at which they become ineligible for currently received services.
- The blending of funds for children needing long-term care and health services.
- Coordination of children's services among health and human services agencies.
- Use of funds appropriated for children's long-term care and health services.
- Services and supports for families caring for children with disabilities.
- Permanency planning for children residing in institutions or at risk for institutionalization.
- Barriers to enforcement of regulations for institutions serving children with disabilities.
- Provision of services under the Medical Assistance Program to children and youth with disabilities.[47]

Texas Council on Children and Families

The Texas Council on Children and Families was established in 2009 by Senate Bill 1646 during the 81st Texas Legislature to help improve the coordination of state services for children.[48] Council member agencies collaborate and leverage resources with the goal of an efficient delivery of services to children, youth and their families.

Ongoing activities include:

- Targeting and addressing cross-system issues.
- Eliminating duplication of services.
- Integrating the efforts of similarly missioned state councils and task forces.
- Inviting public input on issue identification and solution development related to access and quality of services.
- Increasing opportunities for focused communication and collaboration to better serve the needs of Texas residents.

Task Force for Children with Special Needs

The Task Force for Children with Special Needs was established in 2009 by Senate Bill 1825 during the 81st Legislature to coordinate efforts across agencies in improving services for children with special needs and their families.[49] A comprehensive five-year strategic plan (2011-2016) was legislatively mandated to address the difficulties that families of children with disabilities often face due to conflicting requirements, gaps in services and crisis situations that could have been prevented.

Other efforts include the implementation of practices that allow children to live successfully in the community and avoid institutionalization. These include crisis services for children and adolescents, statewide diversionary programs for juvenile offenders, and the use of video-conferencing for the provision of psychiatric services.

Further information on the task force's charge and current activities is available at **www.hhsc.state.tx.us/about_hhsc/AdvisoryCommittees/TaskForce.shtml**.

Promoting Independence Initiative for People with Disabilities

In a 1999 groundbreaking interpretation of the Americans with Disabilities Act (ADA), the U.S. Supreme Court decided in *Olmstead* (L.C., 527 U.S. 581 1999) that people with disabilities have a right to receive care in the most appropriate setting and established that unnecessary institutionalization violates the ADA. All states must now comply with the decision.[50]

In response to the *Olmstead* decision, then Gov. George W. Bush issued Executive Order GWB 99-2. The order required the Texas Health and Human Services Commission to conduct a comprehensive review of all services and support systems available to people with disabilities. The review included an analysis of the availability, application and efficacy of existing community-based alternatives for people with disabilities. The focus of the review was to identify affected populations, improve the flow of information about supports in the community, and remove barriers that impeded opportunities for community placement in light of the Supreme Court ruling.[51] The executive order created the Promoting Independence initiative, including the development of a Promoting Independence Plan, and the formation of the Promoting Independence Advisory Committee. The advisory committee meets once every quarter to monitor plan implementation, analyze system changes needed to increase access to community services, and make recommendations to the executive commissioner and the Texas Legislature.

As described later in the DSHS portion of this section, the resulting Medicaid targeted case management and rehabilitative services are designed to improve care for people with disabilities by increasing opportunities for community living.

Reducing Racial and Ethnic Mental Health Disparities

Health disparities are defined as inequality in access to or quality of health care that is based on race or ethnicity, not on a person's needs or preferences.[52] Despite efforts to address inequities in health care access and outcomes, recent studies show little progress in eliminating mental health treatment disparities for African Americans, Native Americans, Asian and Pacific Islanders, and Hispanic Americans, regardless of whether treatment is provided in primary care or psychiatric settings.[53]

Texas has a large and culturally diverse population that is growing rapidly. For example, while the total population in Texas increased approximately 20% to a current total of 25.8 million from 2000 to 2010,[54] the Hispanic population in Texas rose by 42% to nearly 9.5 million.[55] Demographic changes in Texas have underscored the need to address health disparities in general and mental health disparities specifically.

Recognizing this challenge, HHSC established a number of state and local programs to address disparities in access and outcomes, including the Center for Elimination of Disproportionality and Disparities. One of the more notable programs of the center is the Texas State Partnership to Address and Eliminate Health Disparities. For this three-year project, the center convened a multidisciplinary team of researchers, stakeholders, and public health, substance use and mental health professionals to investigate and provide a better understanding of the contribution of behavioral, biological and socioeconomic variables to disparities in care and outcomes.

Project components include:

- Providing links to the center's statewide network to build the capacity to help develop policy actions relevant to community needs.
- Providing technical support to enhance the leadership skills and capacities of communities in eliminating health disparities in Texas.
- Expanding efforts to identify and strategically confront the connection between health disparities and proposed health care reform strategies.[56]

Approaches to integrating physical and behavioral health care also are being promoted as a promising means to address health disparities and are included as a program initiative under the state's new 1115 Medicaid waiver.[57]

Mental Health Across State Agencies

The Texas health and human services enterprise consists of HHSC and the four departments reporting directly to the HHSC executive commissioner. The remaining information in this section describes not only the behavioral health services provided by these four departments, but also the services provided by agencies external to the enterprise.

Department of State Health Services

The Department of State Health Services (DSHS) is the state mental health authority and state substance abuse authority for Texas. It oversees the public behavioral health service delivery system. Behavioral health services include mental health and substance use services and are provided on a statewide basis.

Management and Delivery of Mental Health and Substance Use Services

The DSHS Mental Health and Substance Use Services Division manages the public system of mental health and substance use services. This includes both community services and inpatient hospital services.

In FY 2010 Texas reported the following prevalence data:

- 488,520 adults had a serious mental illness.
- 154,724 children and adolescents had a serious emotional disturbance.
- 1,752,460 adults had a substance use condition.
- 174,568 youth had a substance use condition.[58]

Local Mental Health Authorities and NorthSTAR

Mental health services are primarily provided through designated local mental health authorities (LMHAs), commonly known as community mental health centers, with one exception. In Dallas and surrounding counties, the North Texas Behavioral Health Authority provides local oversight of a behavioral health "carve-out" program, referred to as NorthSTAR. The NorthSTAR program provides mental health and substance use services to indigent residents and most Medicaid recipients within the service area. Additional information on NorthSTAR is provided later in this section.

DSHS contracts with 39 LMHAs (including NorthSTAR) to provide or arrange for the delivery of community mental health services for a specific geographic area. The LMHAs are required to plan, develop and coordinate local policy and resources for mental health care.[59] All state and federal funds for services flow from DSHS to the LMHAs.

DSHS is advised by the statewide Local Authority Network Advisory Committee on technical and administrative issues that directly affect LMHA responsibilities. The committee reviews and makes recommendations regarding:

- Negotiated rulemaking processes.
- Contract development processes that are flexible and responsive to the needs and services of local communities.
- DSHS performance expectations.
- Coordination with workgroups affecting LMHA operations.[60]

Policy Concerns:

- Potential implementation of Rider 71 study recommendations
- Funding for community services
- Legislative changes to the mental health code
- State hospital privatization
- Waiting lists for community services
- Inpatient capacity
- Competency restoration
- YES waiver renewal
- Development of a 1915(i) waiver

DSHS

Access to Public Mental Health and Substance Use Services

Many people in Texas who need public mental health and substance use services are unable to access them. In 2009, 46% of adults meeting eligibility criteria for behavioral health services through their LMHA received services and 65% of eligible adults in the NorthSTAR service area received services.

Just 17% of eligible children received services through LMHAs and 32% through NorthSTAR.[61] This level of access and utilization indicates a significant gap between services needed and access to those services. Additionally, the percentage of the population utilizing community behavioral health services in Texas (12%) is very low compared with the U.S. (21%), while utilization of Texas state hospitals (0.55%) is higher than the national average (0.51%), indicating the need for more accessible community-based services.[62]

LMHAs operate as the provider of last resort.

The percentage of the population utilizing community behavioral health services in Texas (12%) is very low compared with the U.S. (21%), while utilization of Texas state hospitals (0.55%) is higher than the national average (0.51%), indicating the need for more accessible community-based services.

In 2003, House Bill 2292 included an amendment that required LMHAs to operate as the provider of last resort, a requirement that was designed to encourage them to develop a network of service providers and only fill the role of service provider if they are unable to contract with another local provider.[63] Though this legislation was intended to change the role of the LMHAs and separate the authorization from the delivery of services, a recent study was unable to "find any trend data, administrative oversight, or published studies that measure how well the LMHAs have worked to address the provider of last resort requirements."[64]

DSHS Prioritization Process

DSHS prioritizes access to services for persons who have serious mental health or substance use conditions and are either eligible for Medicaid or determined to be indigent. According to Texas statutes an indigent person is "an individual who: (1) possesses no property; (2) has no person legally responsible for the patient's support; and (3) is unable to reimburse the state for the costs of the patient's support, maintenance and treatment."[65] Medically indigent individuals who meet the priority population criteria (explained below) are eligible to receive DSHS-funded services through the DSHS system.[66]

Within the first 30 days of rendering mental health services, the LMHA conducts a financial assessment of a consumer's ability to pay for services and assesses a maximum monthly fee or no fee, depending on the consumer's income.[67] The same assessment for financial eligibility is conducted for individuals requesting substance use services. Individuals whose adjusted income is at or below 200% of the federal poverty level are eligible for full funding of substance use services; otherwise, they are assessed on a sliding fee basis.[68]

Priority Populations

Texas has made difficult choices in determining eligibility criteria for public mental health and substance use services, particularly among populations who are not eligible for Medicaid and do not have the financial means to pay for care. To help set priorities, DSHS has developed additional criteria to determine eligibility of adults, children and adolescents for publicly funded behavioral health services. These criteria are described below.

Adult Priority Population

Mental Health

The priority population for adult mental health services is defined as those with a severe and persistent mental illness diagnosis of schizophrenia, bipolar disorder or major depression requiring ongoing and long-term support and treatment.

Substance Use

Three populations receive priority for admission to substance use services before all others. They are in order of priority:

- Pregnant, intravenous substance users
- Pregnant substance users
- Intravenous drug users

After these populations have been admitted to services, DSHS will place other individuals referred from the Department of Family and Protective Services into treatment.

Child and Adolescent Priority Population

Mental Health

DSHS serves children ages 3 through 17 who have a diagnosis of mental illness, exhibit serious emotional, behavioral or mental health conditions, and meet at least one of the following criteria:

- Have a serious functional impairment.
- Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms.
- Are enrolled in a school system's special education program because of serious emotional disturbance.

Children and adolescents with a single diagnosis of autism, pervasive developmental disorder, intellectual disability or substance use do not meet the priority population criteria for mental health services.

Substance Use

The child and adolescent priority population definition for substance use services follows the definition outlined for the adult population. Pregnant, intravenous substance users are the highest priority followed by pregnant substance users and intravenous drug users.

Funding Sources and FY 2012 - 2013 Appropriations

The three major sources of funding for DSHS mental health and substance use services are:

- State general revenue (59%)
- Federal funds (25%) (Federal funds include both Medicaid dollars from the Center for Medicaid and Medicare Services as well as block grant funding from the Substance Abuse and Mental Health Services Administration.)
- Local funds (16%)[69]

The following figure details DSHS funds for FY 2011 expenditures and FY 2012/2013 appropriations by budget strategy.

Figure 11. FY 2011 State Expenditures and FY 2012 – 2013 Appropriations (all funds)

Budget Strategy	FY 2011 Expended	FY 2012 Budgeted	FY 2013 Appropriated
Mental Health Services-Adults	$289,632,620	$274,308,791	$282,513,627
Mental Health Services-Children	$67,157,299	$63,925,903	$77,928,014
Community Mental Health Crisis Services	$82,030,378	$82,494,196	$82,459,654
NorthSTAR Behavioral Health Waiver	$100,972,858	$95,907,300	$117,687,025
Substance Use, Prevention, Intervention and Treatment	$149,401,492	$141,701,917	$141,642,849
Mental Health State Hospitals	$387,336,914	$393,854,735	$389,339,514
Mental Health Community Hospitals	$30,118,077	$53,703,096	$53,703,096
Total	$1,106,649,638	$1,105,895,938	$1,145,273,779

Source: Texas Department of State Health Services. (February 27, 2012). Summary of budget by strategy. In *FY 2012 operating budget* (section II.A). Retrieved from www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=53931&id=8589961351&terms=2012+operating+budget and Eighty-second Texas Legislature. (2011). General Appropriations Act for the 2012-2013 biennium. Retrieved from www.lbb.state.tx.us

A full description of DSHS expenditures and appropriations is available through the Texas Legislative Budget Board website at **www.lbb.state.tx.us/Fiscal_Size-up/Fiscal%20Size-up%202012-13.pdf**.

A recent analysis of the DSHS public mental health system, as required by Rider 71 in House Bill 1, 82nd Texas Legislature, and conducted by Public Consulting Group, Inc., concluded that per capita funding levels to DSHS over the past four or five years have been flat because of state population growth and a resulting increase in the number of people seeking services. During that time, average utilization of community-based mental health services decreased while the use of hospital emergency and observation rooms increased.[70] The report is available at **www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf**.

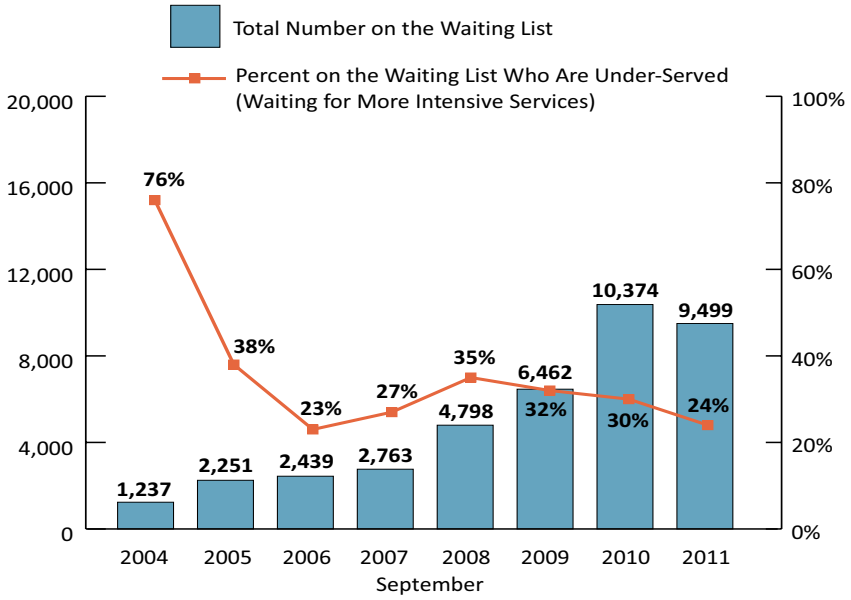
Trends in Mental Health System Access and Utilization of Services

From FY 2008 through FY 2011, a total of 733,935 adults and children received community mental health services through LMHAs and NorthSTAR. The unduplicated number of persons provided mental health services through these entities increased from FY 2008 to FY 2011, largely driven by increased utilization by adults.[71]

The number of adults served through LMHAs and NorthSTAR rose from 205,408 in FY 2008 to 243,259 in FY 2011. The number of children receiving mental health services increased slightly, from 55,266 in FY 2008 to 63,313 in FY 2011.[72] A recent analysis of utilization found that the top five mental health services used statewide were care management, medication, assessment, screening and crisis-intensive rehabilitation.[73]

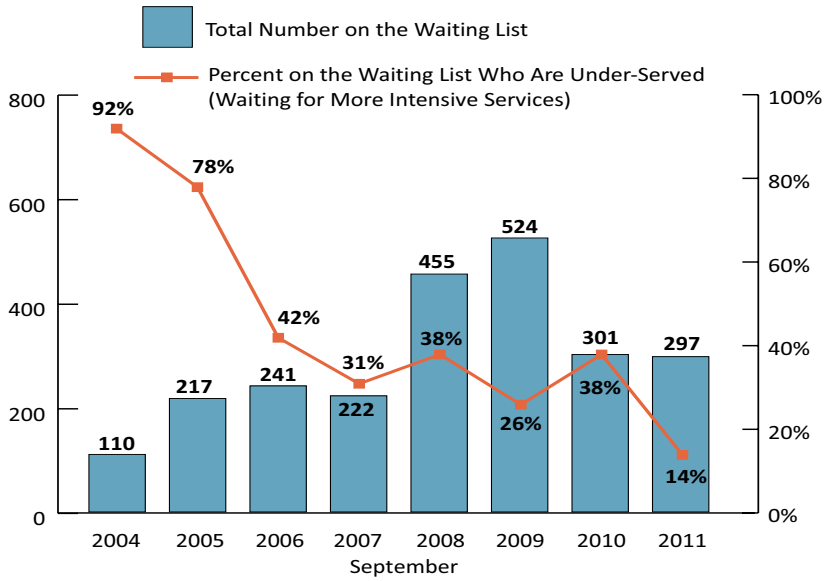
When services are unavailable at the time an individual needs mental health services, DSHS uses a wait list to identify people in need. Although the wait list has decreased since 2010, thousands of people eligible for services still are waiting to receive the necessary mental health services. Figure 12 shows the numbers of adults waiting for services annually over the last eight years. Figure 13 shows waiting list trends for children.[74]

Figure 12. Adults Waiting for On-Going Community Mental Health Services



Source: Maples, M. (July 12, 2012). *Presentation to the House Appropriations Subcommittee on Article II* [PDF document]. Retrieved from **www.dshs.state.tx.us/legislative/default.shtm**

Figure 13. Children Waiting for On-Going Community Mental Health Services



Source: Maples, M. (2012, July 12). *Presentation to the House Appropriations Subcommittee on Article II* [PDF document]. Retrieved from **www.dshs.state.tx.us/legislative/default.shtm**

DSHS Systems Change Initiatives

Despite limited resources, DSHS has made sustained efforts to plan and implement innovation in service delivery through three major initiatives: resiliency and disease management, mental health transformation and continuity of care. Additional DSHS initiatives, described below, include crisis stabilization services, crisis redesign pilots, new outpatient competency restoration pilots, recovery-oriented systems of care and the potential for a 1915(i) waiver.

Resiliency and Disease Management

The state's mental health system is based on a resiliency and disease management (RDM) model. The RDM model relies on evidence-based practices and principles of recovery to obtain the best possible consumer outcomes and maximize available dollars. A uniform assessment is provided to evaluate the needs of consumers and to recommend appropriate packages of services within which individual service plans are customized based on individual needs and preferences.

The result of the assessment is an authorized level of care that corresponds to a service package.[75] Service packages for both adults and children have been developed to provide an appropriate array of evidence-based services for consumers in each level of care.[76]

RDM service definitions are included in Appendix 4. Glossary. For additional RDM services descriptions, please see the following link: **www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm.**

Mental Health System Transformation

In 2005, Texas received a federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant to transform the state's mental health system infrastructure across agencies through "innovative, consumer-focused, practical and

sustainable infrastructure solutions to systemic problems that hinder mental health effectiveness."[77] The core accomplishments of the project include:[78]

- Creation of Via Hope, a consumer, family and youth training and technical assistance center that focuses on recovery and resiliency practices, including statewide peer specialist and family partner training and certification programs.
- Development of learning collaboratives and academies on topics including peer specialist involvement, recovery and supported employment and housing.
- Local change efforts through community collaboratives.
- A focus on addressing the needs of returning veterans and their families funded with appropriations from the 81st and 82nd legislative sessions.
- Advancement of primary and behavioral health care integration and continuity of care.
- Creation of an online clearinghouse on evidence-based practices.
- Support for key components of a new electronic behavioral health record.
- Advancement of technology for suicide prevention training.
- Launch of pilot programs for person-centered self-directed care.

Through the Texas Department of State Health Services (DSHS) Mental Health Transformation initiative, Via Hope, a technical assistance and training center, was created in 2008 with a charge to:[79]

- Provide innovative training and technical assistance initiatives designed to change the traditional mental health system.
- Develop a mental health system that is recovery-oriented, strengths-based and person-centered.
- Promote the use of best practices, promising practices and a variety of diffusion of innovation frameworks.

Via Hope operates the following initiatives to foster a recovery orientation for mental health services:

- Peer support and certified peer specialist training
- Family Partner Certification
- Youth outreach
- Statewide consumer engagement
- Learning communities
- Recovery Institute

Via Hope is funded by DSHS and the Hogg Foundation for Mental Health and administered through Mental Health America of Texas and the National Alliance on Mental Illness of Texas (NAMI Texas). More information on Via Hope can be found on these initiatives in Section 6. Best Practices.

Further information on mental health transformation activities and outcomes is available at **www.mhtransformation.org.**

Continuity of Care

In response to concerns about the inconsistent and uncoordinated care of persons with mental health needs who cycle through jails, emergency departments and inpatient hospitals, as well as insufficient state psychiatric hospital capacity, DSHS convened a

workgroup in 2010 to develop recommendations to address continuity of care issues. The workgroup recommendations address statutory, policy and clinical areas, including:

- Expansion of permanent supported housing, a national best practice for persons who are frequently hospitalized and who are homeless or have unstable housing.
- Creation of "step down" alternatives to inpatient care, including residential care and assisted living programs.
- A shift in DSHS and legislative focus to non-crisis services, to complement new capacity of crisis care.
- Development of emergency community overflow mechanisms to decrease the need for transport to state psychiatric hospitals.
- Training for mental health and criminal justice professionals to improve coordination.
- Enhanced clinical competencies for professionals working in the public mental health system and the expansion of peer support programs.
- Expansion of outpatient competency restoration services by increasing the pilot sites from four to 11.
- Amendments to Chapter 46B of the Texas Code of Criminal Procedure to address issues related to commitments. [80, 81]

Further information on continuity of care efforts is available at **www.dshs.state.tx.us/mhsa/continuityofcare/.**

DSHS Crisis Stabilization Services

In 2007, the 80th Texas Legislature appropriated $82 million to address problems in the state's mental health and substance use crisis service delivery system.[82] The funds were intended to create statewide access to more effective crisis interventions. Similar levels of funding were maintained in the 81st and 82nd legislative appropriations bills. The number of persons using crisis intervention rehabilitation increased dramatically as a result, from almost 31,000 in FY 2007 to over 80,000 in FY 2011.[83]

A crisis is defined as a situation in which:

- Due to a mental health condition, an individual presents an immediate danger to self or others or is at risk of serious deterioration of mental or physical health.
- An individual believes that he or she presents an immediate danger to self or others, or that his or her mental or physical health is at risk of serious deterioration.[84]

Crisis services are available statewide, including hotline services 24 hours a day, seven days a week. Mobile crisis outreach is available by teams who respond to crises in homes and other community locations.

Crisis Services Redesign Pilots

A portion of the new crisis services appropriations was released on a competitive basis to create innovative local strategies to serve persons at risk of incarceration or hospitalization in state facilities. The pilots include the following:[85]

- Licensed crisis stabilization units that provide emergency psychiatric care and short-term residential treatment.
- Extended observation units that provide 23 to 48 hours of observation and treatment.
- Crisis residential services that provide one to 14 days of residential services for persons at risk of harm to self or others.
- Crisis respite services that provide short-term respite support for persons at low risk of harm to self or others.
- Crisis step-down stabilization in hospital settings that provides three to ten days of stabilization in a local hospital with psychiatric staffing.
- Outpatient competency restoration services that provide both community mental health services and restoration services for people charged with a crime but determined by a court to be incompetent to stand trial.

Impact of Crisis Services Redesign

The impact of the crisis services redesign effort was evaluated by Texas A&M University in 2010. The study found that "although crisis service encounters increased almost 24% from 2007 to 2008, the cost per encounter was reduced by almost the same amount. As a result, total program cost decreased by 5.4% despite the increased consumer load."[86] In response to the positive outcomes identified in the study, the 81st Texas Legislature maintained funding and appropriated an additional $52 million for the following:

- Transitional services for up to 90 days for people with serious mental illness who are coming out of crisis but are not in ongoing treatment. The funding is targeted for people who are homeless, in the criminal justice system, or have a history of multiple hospital readmissions.
- Ongoing services to expand intensive treatment capacity for children and adults coming out of a crisis, hospitalization or incarceration.

New Outpatient Competency Restoration Pilots

Rider 78 in House Bill 1 of the 82nd Legislature directed DSHS to fund at least five new outpatient competency restoration (OCR) pilots in addition to continuing funding of four existing OCR pilot programs. Funding for these programs included an increase of $1.8 million annually.[87] The 11 OCR pilot sites around the state have served 662 clients since inception in 2008.[88]

The majority (67%) of clients who completed the program had positive outcomes. Outcomes included the following:

- 49% restored to competency.
- 18% improved enough to have their charges dropped and be enrolled in community services.
- 26% were not restored.
- 4% had an extended commitment.

The average cost for OCR services was approximately $140 per day compared to $407 per day in the state forensic hospitals; per treatment episode costs were $12,013 compared to an average of $33,238 in state forensic hospitals (based on an average 86-day duration).[89]

1915(i) Medicaid Waiver

Section 1915(i) of the Social Security Act provides states an opportunity to offer Medicaid services and supports before individuals need institutional care. It also provides a mechanism to provide state Medicaid home and community-based services to individuals with mental health and substance use disorders.

As originally enacted, however, states were unable to target 1915(i) services to particular populations and could only serve individuals whose incomes did not exceed 150% of the federal poverty level. Additionally, the original service package available under 1915(i) included some, but not all, of the home and community-based services available through waivers. The changes to 1915(i) under the Affordable Care Act enhance an important tool for states in their efforts to serve individuals in the most integrated setting and to meet state obligations under the Americans with Disabilities Act (ADA) and the Olmstead Supreme Court decision. In order to promote state utilization of 1915(i), the ACA includes changes that make community services accessible to more individuals and help to ensure the quality of services.[90]

Recovery-Oriented System of Care

DSHS has begun the statewide implementation of a recovery-oriented system of care (ROSC) initiative. The initial elements of the ROSC initiative are being developed in communities to help ensure that persons affected by substance use and mental health conditions are provided a continuum of services and a continuous path to recovery.

DSHS is promoting understanding of the ROSC concept in local communities across the state. To accomplish this, DSHS staff has:

- Conducted on-site informational trainings to organize communities assisting them with the development of the initial phase of this systems change approach for achieving recovery.
- Provided telephone and email technical assistance to local communities regarding the ROSC concept.
- Participated in person and via teleconferencing in local ROSC community meetings.
- Added a week-long educational track on recovery during Texas's Behavioral Health Training Institute.
- Assisted with development and training of recovery coaches.[91]

Community Mental Health for Adults

The array of community mental health services for adults includes both ongoing services and crisis services.

Ongoing Treatment

Ongoing treatment begins with services such as evaluation, assessment and diagnosis. This culminates in the development of inter-disciplinary treatment plans. Available ongoing services include consumer and family education, case management, rehabilitation and medication services including appropriate lab work. Rehabilitative services include supported housing, employment, education, medical (including dental) and other services essential to meeting individualized goals. Flexible dollars are a part of this array of services. They are currently used primarily to address transportation barriers and housing needs.

Crisis Services

Crisis services are available to consumers whether or not they are enrolled in ongoing care. Crisis services include:

- 24-hour emergency screening and mobile crisis outreach teams.
- Crisis respite/residential services.
- 23- or 48-hour observation services.
- Local hospitalization if needed for stabilization.

Resiliency and Disease Management Service Packages for Adults

As stated earlier in this section, the state's mental health system is based on a resiliency and disease management (RDM) model. The RDM model relies on evidence-based practices and principles of recovery to obtain the best possible consumer outcomes and maximize available dollars. Figure 14 describes the target population and services for each RDM service package for adults.[92]

Figure 14. Resiliency and Disease Management (RDM) Service Packages for Adults

Service Package	Target Population and Service Goal	Services
Service Package 0	General population in crisis.	Brief interventions to address the immediate crisis and prevent the need for more intensive services.
Service Package 1	Adults with major depressive disorder, bipolar disorder or schizophrenia and related conditions who present with little risk of harm and have personal supports and a level of functioning that does not require higher levels of care. The goal of these services is to reduce or stabilize symptoms, improve the level of functioning, or prevent deterioration of the person's condition. Services are provided in outpatient and office-based settings.	Pharmacological management services, routine case management, medication training & support services.
Service Package 2	Adults with residual symptoms of major depressive disorder who present little risk of harm, have social supports, do not require more intensive intervention, and can benefit from psychotherapy. The goal of this level of care is to improve functioning and prevent deterioration of the person's condition. Services are most often provided in outpatient and office-based settings.	Service Package 1 + psychotherapy.
Service Package 3	Adults who enter the system of care with moderate to severe levels of need. This level of care utilizes a team approach to provide more intensive rehabilitative services to increase community tenure, establish support networks, and develop coping strategies to function effectively. A rehabilitative case manager who is a member of the therapeutic team must ensure individuals receive supported housing and co-occurring substance use services. The general goal of this package is to stabilize symptoms, improve functioning, develop skills in self-advocacy, increase natural supports in the community, and sustain improvements. Services are provided in outpatient office-based settings and community settings.	Intensive multi-component rehabilitative interventions using a team-based approach.
Service Package 4	People with severe and persistent mental illness who have a history of multiple hospitalizations. Assertive Community Treatment (ACT) is provided, which is a self-contained program with comprehensive wraparound services and supports provided by a team of professionals.	Pharmacological management, psychosocial rehabilitative services, medical and medication-related services, supported employment, supported housing, and co-occurring psychiatric and substance use services.
Service Package 5	Post-crisis follow-up services.	This package provides up to 90 days of services following a crisis to prevent the need for longer-term treatment.

Source: Texas Department of State Health Services. (March 31, 2010). Local planning and network development service package definitions. Retrieved from www.dshs.state.tx.us/mhcommunity/LPND/definitions.shtm

Sample RDM service descriptions are included in Appendix 4. Glossary. For additional RDM services descriptions, please see the following link: **www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm.**

Utilization and Costs

The utilization and costs for adult community mental health services in Texas are included in Figure 15 below.

Figure 15. Utilization/Cost for Adult Community Mental Health Services

	FY 2010	FY 2011	FY 2012
Average monthly number receiving community mental health services.	81,592	80,000	77,592
Average cost of community mental health services per adult served.	$345	$380	$368
Number of adults on waiting list.	8,921	9,252	8,463

Note: Data are from each year's third quarter. Source: Texas Department of State Health Services. (July 9, 2012). *Behavioral health data book, FY 2012, third quarter* [PowerPoint slides]. Retrieved from **www.dshs.state.tx.us/mhsa/databook/**

Quality of Care Measures

Selected data from FY 2010 to FY 2012 on common adult outcome measures are provided in the Figure 16 below. Other quality measures are reported in the Behavioral Health Databook, available at **www.dshs.state.tx.us/mhsa/databook**.

Figure 16. Selected Quality of Care Measures for Adults Receiving Community Mental Health Services

	FY 2010	FY 2011	FY 2012
Percentage of adults in community mental health services receiving first service encounter within 14 days of assessment.	78%	81%	83%
Percentage of adults in community mental health services avoiding crisis.	97%	98%	99%
Percentage of adults in community mental health services admitted 3 or more times in 180 days to a state or community psychiatric hospital.	0.38%	0.36%	0.35%
Percentage of adults in community mental health services with improved or acceptable functioning per year.	34%	35%	N/A
Percentage of adults in community mental health services with improved or acceptable employment per year.	84%	86%	N/A

Note: Data for first three are from each year's third quarter. Source: Texas Department of State Health Services. (July 9, 2012). *Behavioral health data book, FY 2012, third quarter* [PowerPoint slides]. Retrieved from **www.dshs.state.tx.us/mhsa/databook/**

Community Mental Health for Children

Services are available for children ages three through 17 with a diagnosis of mental illness who exhibit serious emotional, behavioral or mental disturbances and are in at least one of the following situations:

- Have a serious functional impairment.
- Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms.
- Are enrolled in a school system's special education program because of a serious emotional disturbance.

A system of care philosophy, as described previously, is child-centered and family-driven. Services are delivered through service packages based on the RDM model for children, as described in Figure 17.

Resiliency and Disease Management Service Packages for Children

Eligible children are matched to service packages based on their needs and the preferences of their caregivers.

Services for this population may include:

- 24-hour emergency screening and rapid crisis stabilization service
- Community-based crisis residential services or hospitalization
- Community-based assessments, including the development of inter-disciplinary treatment plans and diagnosis and evaluation services
- Family support services, including respite care
- Case management services
- Medication management
- Counseling
- Skills training development

Children and their families have access to three levels of case management services, depending on their specific needs. These include:

- Routine case management
- Intensive case management
- Family case management

The mental health case manager works with other service providers to address additional needs of the child, such as education, criminal justice issues, substance use, physical health issues, and rehabilitation, employment and housing for older adolescents transitioning to adulthood. The most intensive service packages utilize wraparound treatment planning based on the system of care philosophy.[93]

Figure 17 describes the target population and services for each RDM service package for children.

Figure 17. Resiliency and Disease Management (RDM) Service Packages for Children

Service Package	Target Population & Service Goal	Services
1.1 Externalizing Conditions	Includes children and adolescents with externalizing conditions such as ADD/ADHD, conduct or oppositional defiant disorder and a moderate level of functional impairment. The focus of the intervention is on psychosocial skill development in the child and the enhancement of parenting skills, especially in child behavior management. This level of care generally is considered short-term and time-limited. The general goal of services at this level of care is to reduce or stabilize symptoms, decrease functional impairment or prevent deterioration of the child's condition. Family support is facilitated through links to natural and community resources. Services are provided in the office, school, home or other community setting.	Skills training & development, medication training & support, routine case management.
1.2 Internalizing Conditions	Includes children and adolescents with internalizing conditions such as depression or anxiety and a moderate level of functional impairment. The focus of the intervention is on child and family counseling using cognitive behavioral therapy (CBT) for ages 9 and older and CBT or other therapy approaches for children ages 3 through 8. This level of care is generally considered short-term and time-limited. The general goal of services at this level of care is to reduce or stabilize symptoms, decrease functional impairment or prevent deterioration of the child's condition. Services are provided in the office, school, home or other community setting.	Counseling, medication, training & support, routine case management, parent support group.
2.1 Multi-Systemic Therapy	Includes youth with externalizing conditions and high levels of severe disruptive or aggressive behaviors. Youth could be in the juvenile justice system or at high risk of out-of-home placement due to presenting behaviors. The family service plan is developed using a wraparound planning approach.	This service is not currently offered. Intensive parent-to-parent peer support is available to the family.
2.2 Externalizing Conditions	Includes children and adolescents with externalizing conditions and moderate to high functional impairment at home, school or in the community. The family service plan is developed using a wraparound planning approach. Multi-systemic therapy either is not appropriate due to lack of juvenile justice involvement or unavailable.	Intensive case management, skills training & development, medication training & support, family partner, and parent support group. Intensive case management and significant parent support is provided.
2.3 Internalizing Conditions	Includes children and adolescents with depressive or anxiety conditions and a moderate to high level of problem severity or functional impairment. The focus of the intervention is on child and family counseling using CBT for ages 9 and older and CBT or other therapy approaches for children ages 3 through 8. The family service plan is developed using a wraparound planning approach.	Intensive case management, counseling, medication training & support, family partner, and parent support group. Multiple family concerns and significant parental stress indicate the need for intensive case management and the availability of parent-to-parent peer support.

Service Package	Target Population & Service Goal	Services
2.4 Major Conditions	Includes children and adolescents who are diagnosed with bipolar disorder, schizophrenia, major depression with psychosis, or other psychotic conditions and are not yet stable on medication. The major focus is on stabilizing the child and providing information and support to the family.	Psychiatric evaluation, intensive case management, medication training & support, family partner, parent support group, and flex funds. Flex funds pay for non-clinical supports that augment the service plan to reduce symptomatology and maintain quality of life and family integration, such as respite, mentors or child care.
4. Aftercare Services	Includes children and adolescents who have stabilized in terms of problem severity and functioning and require only medication and medication management to maintain their stability.	Medication management, routine case management, and parent support.

Source: Texas Department of State Health Services. (March 2010). Local Planning and Network Development Service Package Definitions. Retrieved from www.dshs.state.tx.us/mhcommunity/LPND/definitions.shtm

Utilization and Cost

The utilization and costs for children's community mental health services are shown in Figure 18 below.

Figure 18. Utilization and Costs for Children's Community Mental Health Services

	FY 2010	FY 2011	FY 2012
Average monthly number of children receiving community mental health services.	18,951	18,769	18,341
Average cost of community mental health services per child served.	$387	$357	$352
Number of children on waiting list.	607	416	347

Note: Data are from each year's third quarter. Source: Texas Department of State Health Services. (July 9, 2012). *Behavioral health data book, FY 2012, third quarter* [PowerPoint slides]. Retrieved from www.dshs.state.tx.us/mhsa/databook/

Quality of Care Measures

DSHS monitors quality and performance in several areas of care based on the RDM framework. Figure 19 below highlights measures examined for children's mental health services.

Figure 19. Selected Quality of Care Measures for Children Receiving Community Mental Health Services

	FY 2010	FY 2011	FY 2012
Percentage of children in community mental health services receiving first service encounter within 14 days of assessment.	73%	77%	79%
Percentage of children in community mental health services avoiding crisis.	98%	98%	98%
Percentage of children in community mental health services admitted 3 or more times in 180 days to a state or community psychiatric hospital.	0.06%	0.07%	0.06%
Percentage of children in community mental health services with improved or acceptable functioning per year.	38%	37%	N/A
Percentage of children in community mental health services with improved or acceptable problem severity per year.	41%	41%	N/A

Note: Data are from each year's third quarter. Source: Texas Department of State Health Services. (July 9, 2012). *Behavioral health data book, FY 2012, third quarter* [PowerPoint slides]. Retrieved from **www.dshs.state.tx.us/mhsa/databook/**

Youth Empowerment Services (YES) Waiver

Youth Empowerment Services (YES) is a Medicaid 1915(c) home and community-based waiver for children up to 19 years of age, intended to reduce Medicaid psychiatric hospital expenses and out-of-home placement for children with serious emotional disturbance. A full range of Medicaid services and non-traditional services and family supports are available to create an intensive and individualized child and family plan of care.

The YES waiver was developed in part to help reduce the need for parental relinquishment, in which parents are forced to give up custody of their children in order to obtain intensive behavioral health services that are not otherwise available or they simply cannot afford. The waiver disregards parental income and deems children to be financially eligible if they meet the same eligibility standards for psychiatric institutions.

DSHS contracts with LMHAs in Travis, Bexar and Tarrant counties to manage YES waiver services in each of these service areas. The LMHAs then contract with community providers to ensure all needed services are available. Austin Travis County Integral Care is currently providing services in Travis County; the Center for Health Care Services is providing services in Bexar County; and Youth Advocate Programs, Inc. is providing services in Tarrant County in collaboration with the Tarrant County LMHA. The YES waiver is approved to serve up to 300 youth at any time (100 per county). However, participant enrollment is occurring gradually and is based on the capacity of the contracted waiver provider agencies. Future expansion to Harris County is anticipated in April 2013. [94]

The waiver is being evaluated to determine if it is cost-effective and is subject to renewal by the federal government in 2013. Further information is available at **www.dshs.state.tx.us/mhsa/yes/**.

NorthSTAR

The single exception to DSHS's LMHA arrangement is NorthSTAR, a behavioral health managed care program covering the seven-county area surrounding and including Dallas. NorthSTAR integrates public mental health and substance use services for both Medicaid-covered and medically indigent individuals. A private behavioral health organization, Value Options, is responsible for service delivery, network development, utilization management and claims payment, with local oversight by North Texas Behavioral Health Authority. This LMHA does not provide direct behavioral health services, but does carry out the same local planning, policy and resource development functions as other LMHAs.

All persons enrolled in Medicaid in the Dallas service area are enrolled in NorthSTAR whether they use a behavioral health service or not. In the second quarter of state FY 2012, the unique count of Medicaid enrollees in NorthSTAR was 507,212. In that same quarter, NorthSTAR served 19,436 Medicaid-eligible persons and 20,227 indigent adults and children.[95]

Eligibility for NorthSTAR services is available to persons living in the Dallas service area who meet the DSHS priority population criteria with adjusted income at or below 200% of the federal poverty level. NorthSTAR is required to make services available in its service area to all Medicaid-eligible persons and others who meet the DSHS priority population criteria. NorthSTAR does not have a waiting list because, by contract, it is required to serve all eligible persons.

NorthSTAR Services

NorthSTAR is required to follow the DSHS RDM guidelines in providing services to adults and children. Services include the RDM service packages, Medicaid-covered services and value-added optional services that NorthSTAR elects to provide to the eligible population, such as consumer drop-in centers, early intervention, school-based services and minority outreach. Figure 20 lists NorthSTAR's behavioral health services available to adults and children.

Figure 20. NorthSTAR Behavioral Health Benefits

Service	Adult	Child
Assessment	X	X
Outpatient counseling	X	X
Mental health intensive outpatient	X	X
Day treatment	X	
Community support services	X	X
Mental health, chemical dependency civil commitment	X	X
Medication services: pharmacological management	X	X
Injection administration	X	X
Medications, including new generation medications	FFS* or HMO	FFS or HMO
Laboratory services	FFS or HMO	FFS or HMO
Acute inpatient hospitalization	X	X
Sub-acute inpatient hospitalization	X	X
23-hour observation bed	X	X
Partial hospitalization	X	X
Supported employment	X	
Supported housing	X	
Respite care	X	X
Intensive crisis residential	X	X
Residential treatment centers	X	X
Personal care homes/assisted living	X	
Adult foster care	X	
Early Intervention		X
Early childhood preschool day treatment		X
Treatment foster care		X
Therapeutic foster care		X
Mental health services – birth to age 6		X
Children/youth wraparound		X
Mobile crisis	X	X
Crisis stabilization	X	X
Emergency room services (facility charges) – for specialized behavioral health facility only	X	X
Emergency department visits (charges by psychiatrists or other behavioral health professionals)	X	X
Transportation	FFS or HMO	FFS or HMO

*Fee-for-service (FFS). Source: Texas Health and Human Services Commission & Texas Department of State Health Services. (June 2012). Analysis of the Texas public behavioral health system. Retrieved from www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf

Utilization and Costs

The following figures include the utilization and costs of services provided by the NorthSTAR program. The most commonly utilized mental health services among the NorthSTAR membership were outpatient services.

Figure 21. Utilization of NorthSTAR Services

	2010	2011	2012
Medicaid	17,250	19,537	19,436
Indigent	21,196	23,464	20,272

Note: Data are from each year's second quarter. Texas Department of State Health Services. (July 9, 2012). *Behavioral health data book, FY 2012, third quarter* [PowerPoint slides]. Retrieved from www.dshs.state.tx.us/mhsa/databook/

Figure 22. Monthly Cost of NorthSTAR Services

	FY 2010	FY 2011
Total direct service expenditures, including civil state hospital allocation	$11,061,851	$11,111,192
DSHS payment including civil state hospital allocation (excluding adult Medicaid)	$12,020,226	$11,523,220

Note: Data are from August of each year. Source: North Texas Behavioral Health Authority. (2012). Local area service plan FY 2012 - 2013. Retrieved from www.ntbha.org/docs/NTBHA_LSAP_01-30-12.pdf

Quality of Care Measures

DSHS monitors NorthSTAR on multiple quality and performance measures. Results for selected measures are highlighted in Figure 23 below.

Figure 23. Selected Quality of Care Measures for NorthSTAR

	FY 2009	FY 2010	FY 2011
NorthSTAR enrollee receiving community services within 7 days after receiving ER services or 23-hour observation (Qtr. Avg.)	26%	26%	24%
NorthSTAR enrollees receiving community services within 30 days of Community Hospital discharge (Qtr. Avg.)	59%	61%	57%
NorthSTAR enrollees receiving Emergency or Crisis services within 30 days of Community Hospital discharge (Qtr. Avg.)	4%	5%	4.5%

Source: Texas Department of State Health Services. (2012). NorthSTAR Data Book, Q1 2012. Retrieved www.ntbha.org/reports.aspx

Substance Use Services

Substance use prevention services include education, skills training for youth and families, community coalition-building and regional information clearing houses. Intervention services include screening, assessment and referral services, testing and case management for persons with HIV, specialized female services such as pregnant/postpartum outreach, and special initiatives such as the rural border intervention program for persons at high risk of developing substance use problems. Both inpatient and outpatient services are available, but waiting lists do exist for residential treatment services.

Eligibility for Services

For individuals who are not eligible for Medicaid, substance use program providers are required to conduct a financial assessment of individuals who seek DSHS-funded substance use services. Individuals whose adjusted income is at or below 200% of the federal poverty level are eligible for fully funded substance use services. If adjusted income is greater than 200%, individuals will be assessed a fee on a sliding scale.

The following figure lists substance use services DSHS makes available to eligible adults and youth.

Figure 24. Availability of Substance Use Services Through DSHS

Services	Service Available to Adults	Service Available to Youth
Screening	X	X
Assessment	X	X
Residential intensive	X	X
Residential intensive (specialized female)	X	X
Residential intensive (women and children)	X	
Residential supportive	X	X
Residential supportive (specialized female)	X	X
Residential supportive (women and children)	X	
Residential detox	X	
Residential detox (specialized female)	X	
Ambulatory detox	X	
Ambulatory detox (specialized female)	X	
HIV residential	X	
Outpatient services	X	X
Individual	X	X
Group	X	X
Adolescent support		X
Family counseling		X
Family support		X
Psychiatrist consultation		X
Outpatient services (specialized female)	X	X
Individual	X	X
Group	X	X
Opioid substitution therapy	X	
Co-occurring psychiatric & substance use conditions	X	X

Source: Texas Health and Human Services Commission & Texas Department of State Health Services. (June 2012). Analysis of the Texas public behavioral health system. Retrieved from www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf

Utilization and Costs

The following two figures show the utilization and costs of substance use services. Figure 25 details information for adults; Figure 26 for children.

Figure 25. Utilization and Costs for Adult Substance Use Services

		2009	2010	2011
Prevention program	Number served per year	366,810	409,585	468,054
	Average cost per adult per year	$20	$19	$16
Intervention programs	Number served per year*	180,586	128,281	123,914
	Cost per adult per year	$64	$97	$89
Treatment programs	Number per year	41,348	42,194	31,627
	Cost per adult per year	$1,827	$1,888	$1,617
Number on the wait list for substance use treatment**		10,948	10,347	8,193

*The spike in number served in FY 2009 is due to instruction from program staff to providers of DSHS-funded substance abuse intervention services to try their best to provide DSHS with client counts, which inadvertently led to duplication. Then, in FY 2010, program staff instructed providers to try their best to provide unduplicated client counts, resulting in another dip. **Total of adults entered on waiting list by following substance abuse programs: COPSD, Detox, Methadone, Outpatient and Residential. Sources: Texas Department of State Health Services. (July 9, 2012). *Behavioral health data book, FY 2012, third quarter* [PowerPoint slides]. Retrieved from www.dshs.state.tx.us/mhsa/databook/ and Texas Department of State Health Services. (October 7, 2010). Behavioral health data book, FY 2010, fourth quarter [PowerPoint slides]. Retrieved from www.dshs.state.tx.us/mhsa/databook/

Figure 26. Utilization and Costs for Children's Substance Use Services

		2009	2010	2011
Prevention program	Number served per year	1,300,834	1,516,959	1,843,263
	Average cost per youth per year	$21	$18	$14
Intervention programs	Number served per year*	81,878	33,962	26,519
	Cost per youth per year	$43	$93	$127
Treatment programs	Number per year	6,302	5,804	5,418
	Cost per youth per year	$2,910	$3,569	$3,713
Number on the wait list for DSHS-funded substance use treatment**		612	809	753

*The spike in number served in FY 2009 is due to instruction from program staff to providers of DSHS-funded substance abuse intervention services to try their best to provide DSHS with client counts, which inadvertently led to duplication. Then, in FY 2010, program staff instructed providers to try their best to provide unduplicated client counts, resulting in another dip. **Total entered on waiting list by following substance abuse programs: COPSD, Detox, Methadone, Outpatient and Residential. Sources: Texas Department of State Health Services. (July 9, 2012). *Behavioral health data book, FY 2012, third quarter* [PowerPoint slides]. Retrieved from www.dshs.state.tx.us/mhsa/databook/ and Texas Department of State Health Services. (October 7, 2010). Behavioral health data book, FY 2010, fourth quarter [PowerPoint slides]. Retrieved from www.dshs.state.tx.us/mhsa/databook/

Quality of Care Measures

DSHS monitors quality and performance in several areas based on the RDM framework. The following figure shows representative measures tracked on a regular basis.

Figure 27. Selected Quality of Care Measures for Adult Substance Use Services

	FY 2009	FY 2010	FY 2011
Percentage of adults completing substance use treatment programs per year	63%	58%	56%
Percentage of adults completing substance use treatment programs reporting abstinence at follow-up per year	86%	85%	89%
Percentage of unemployed adults completing substance use treatment programs gaining employment at follow-up per year	62%	57%	52%
Percentage of adults completing substance use treatment programs not re-arrested per year	98%	98%	100%

Sources: Texas Department of State Health Services. (July 9, 2012). *Behavioral health data book, FY 2012, third quarter* [PowerPoint slides]. Retrieved from www.dshs.state.tx.us/mhsa/databook/ and Texas Department of State Health Services. (October 7, 2010). Behavioral health data book, FY 2010, fourth quarter [PowerPoint slides]. Retrieved from www.dshs.state.tx.us/mhsa/databook/

Figure 28. Selected Quality of Care Measures for Youth Substance Use Services

	FY 2009	FY 2010	FY 2011
Percentage of youth completing substance use treatment programs per year	63%	55%	54%
Percentage of youth completing substance use treatment programs reporting abstinence at follow-up per year	85%	83%	89%
Percentage of youth completing substance use treatment programs with positive school status at follow-up per year	93%	91%	83%
Percentage of youth completing substance use treatment programs not re-arrested per year	96%	97%	99%

Sources: Texas Department of State Health Services. (July 9, 2012). *Behavioral health data book, FY 2012, third quarter* [PowerPoint slides]. Retrieved from www.dshs.state.tx.us/mhsa/databook/ and Texas Department of State Health Services. (October 7, 2010). Behavioral health data book, FY 2010, fourth quarter [PowerPoint slides]. Retrieved from www.dshs.state.tx.us/mhsa/databook/

Co-Occurring Psychiatric and Substance Use Conditions

Mental illness and substance use commonly occur in persons at the same time. Nationally, 42% of adults with substance use conditions also have a mental illness.[96] Best practices prescribe treating the conditions simultaneously. DSHS contracts with 488 outpatient substance use treatment facilities and 160 residential treatment facilities for this specialty service.[97]

DSHS State Inpatient Psychiatric Hospitals

The state of Texas owns and DSHS operates nine state inpatient psychiatric hospitals and one inpatient residential youth treatment facility. Each LMHA and NorthSTAR receive an allocation of state hospital resources to coordinate inpatient mental health services for persons residing in counties within a corresponding state hospital's service area. DSHS designates LMHAs as responsible for achieving continuity of care in meeting a person's need for mental health services in the least restrictive environment. Within this continuum of care, the state hospital's primary purpose is to stabilize persons admitted

by providing inpatient mental health treatment. Chapter 411 of the Texas Administrative Code defines inpatient mental health treatment as residential care including medical services, nursing services and social services, as well as therapeutic activities and psychological services ordered by the treating physician.[98] In FY 2011, DSHS provided funding to Montgomery County to open a forensic facility that provides competency restoration for up to 94 adults. In FY 2012, DSHS provided new funding to Harris County for 20 additional competency restoration beds in the Houston area.

Access to State-Operated Inpatient Psychiatric Hospitals

Admission to state hospitals can occur voluntarily or involuntarily. Involuntary admissions include civil and forensic commitments. The state also has provisions for the commitment of persons with intellectual disabilities experiencing acute psychiatric illness.

Typically, an LMHA screens persons who are self-referred or referred by a community source, such as a police officer. If a person seeks admission independent of an LMHA, the state hospital by law must conduct an emergency psychiatric screening that could result in the person's admission to a state hospital. In consultation with the LMHA, the admitting physician has final authority for admitting persons, consistent with the availability of hospital resources.[99]

State-Owned Psychiatric Hospital Bed Capacity by Population

Across all bed types by population served—adult, adolescent and children—there are 2,461 beds available among the state-owned inpatient psychiatric hospitals in Texas, as shown in Figure 29 below. This number excludes publicly funded beds located at community and private hospitals.

Figure 29. Number of Mental Health Beds, by Bed Types, at State Hospitals in Texas, FY 2012

State Mental Health Hospitals	Bed Type	Number of Beds
Austin State Hospital	Adults, adolescents and children	299
Big Spring State Hospital	Adults only	200
El Paso Psychiatric Center	Adults, adolescents and children	74
Kerrville State Hospital	Adults only	202
North Texas State Hospital Vernon Campus, 343 beds Wichita Falls, 257 beds	Adults and adolescents	600
Rio Grande State Center	Adults only	55
Rusk State Hospital	Adults only	335
San Antonio State Hospital	Adults and adolescents	302
Terrell State Hospital	Adults, adolescents and children	316
Waco Center for Youth	Adolescents only	78
Total, all bed types		2,461

Source: Texas Department of State Health Services. (April 2012) *Mental Health State Hospitals* [PowerPoint slides]. Retrieved from www.dshs.state.tx.us/WorkArea/DownloadAsset.aspx?id=8589966342

State-Funded Community Hospitals

DSHS also contracts with *community* hospitals for additional psychiatric bed capacity, currently at a level of 372 beds, as shown in Figure 30. These contracted community hospital beds are available at:

- Sunrise Canyon Hospital in Lubbock
- University of Texas Harris County Psychiatric Center in Houston
- Montgomery County Mental Health Treatment Facility in Conroe
- Gulf Coast Center in Galveston (Funds provided to purchase at least 16 psychiatric beds at other hospitals in its region, and to provide access to crisis respite services for at least 10 persons.)

Publicly Funded Psychiatric Bed Availability

There are currently 2,963 total inpatient beds available through state facilities, community hospitals and private hospitals for general psychiatric (civil), forensic and maximum-security commitments (Figure 30).[100] Each LMHA and NorthSTAR receives an allocation of state hospital beds for persons in their catchment areas.

Persons on civil commitments have symptoms of mental illness that result in being a danger to themselves or others. Civil commitments can be for 24-hour emergency detention, 30-day orders of protective custody or 90-day court-ordered mental health services (which can be extended up to 12 months by the court).

Patients on a forensic commitment have been admitted to a state hospital by judicial order because they have been determined to not have the capacity to stand trial or found not guilty by reason of insanity.

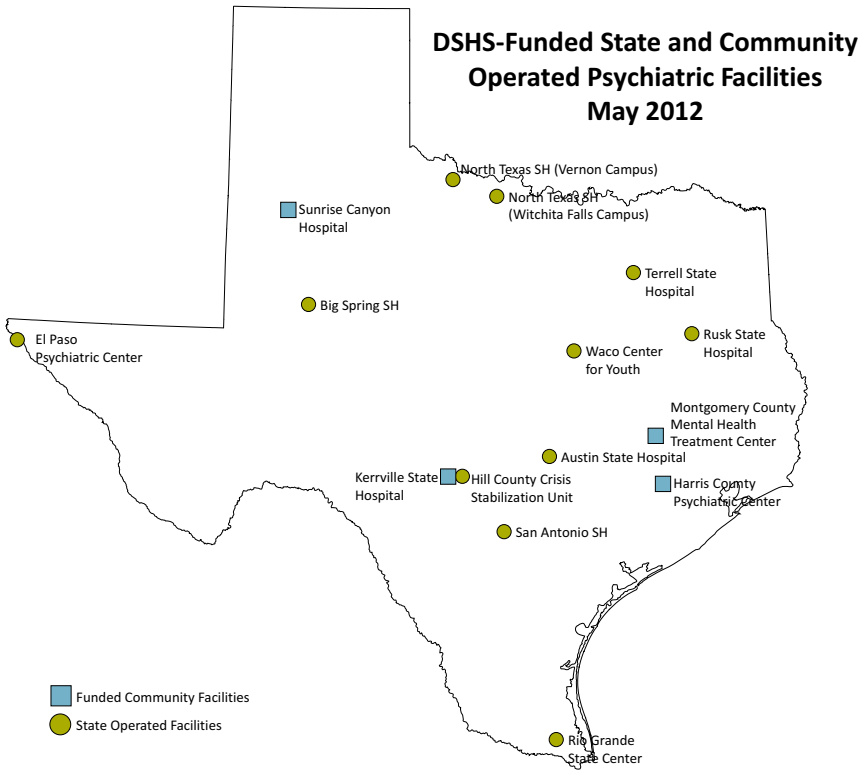
Figure 30. Inpatient Beds Funded by DSHS

	General Psychiatric (Civil)	Forensic (Non-Maximum Security)	Maximum Security
State hospitals	1,509	626	366
Community hospitals	252	120	0
Private hospitals	90	0	0
Subtotal	1,851	746	366
Total beds statewide (all types):		**2,963**	

Source: Maples, M. (July 12, 2012). *Presentation to the House Appropriations Subcommittee on Article II* [PDF document]. Retrieved from **www.dshs.state.tx.us/legislative/default.shtm**

Figure 31 shows the location of each state hospital and the community facilities that DSHS funds.

Figure 31. DSHS-Funded State and Community-Operated Psychiatric Facilities



Source: Texas Health and Human Services Commission & Texas Department of State Health Services. (June 2012). Analysis of the Texas public behavioral health system. Retrieved from **http://www.publicconsultinggroup.com/client/txdshs/documents/Analysis%20of%20the%20Texas%20Public%20Behavioral%20Health%20System.pdf** (Note: Map omits Gulf Coast Center in Galveston.)

As shown in Figure 32, Texas has 18.1 psychiatric beds per 100,000 adults compared to the national average of 23.7. However, state hospital utilization in Texas is higher (0.55 per 1,000 population per year) than the U.S. average of 0.51 per 1,000 per year.[101] With a relatively lower capacity but higher utilization rate, these statistics indicate that the average length of stay in Texas is shorter compared to the U.S average, possibly resulting in more frequent admissions.

Figure 32. Number of Inpatient State and Local Psychiatric Beds Per 100,000 Adults

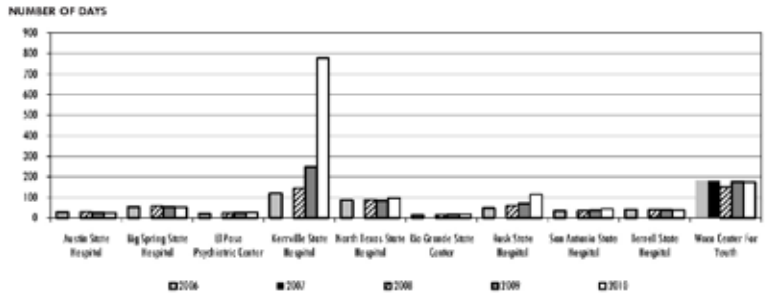
Number of Inpatient State and Local Psychiatric Beds Per 100,000 Adults	
Texas average	18.1
U.S. average	23.7

Source: Substance Abuse and Mental Health Services Administration. (2012). Mental Health, United States, 2010 (HHS Publication No. SMA 12-4681). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Average Length of Stay

Texas state hospitals have seen an increase in the average length of patient stays in recent years. The average length of stay at discharge from state hospitals was 44.5 days in FY 2006, 43.5 days in FY 2007, 47.3 days in FY 2008, 46.3 days in FY 2009 and 51.5 days in FY 2010. The annual average increased 16% from FY 2006 to FY 2010. Figure 33 shows the average length of stay at discharge for each state hospital from FY 2006 through FY 2010.[102]

Figure 33. Average Length of Stay at Discharge from State Hospitals (FY 2006 - 2010)



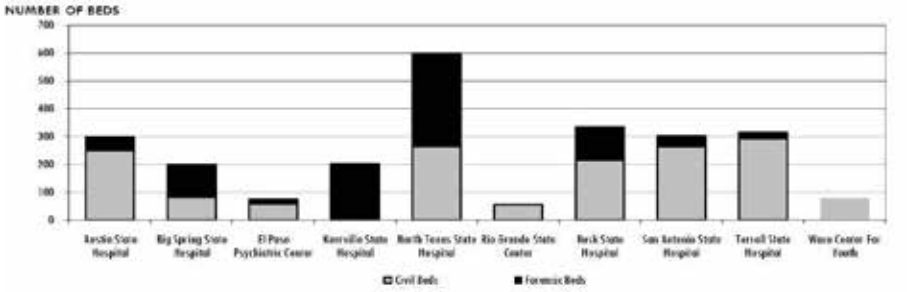
Source: Texas Legislative Budget Board. (February 2011). Managing and funding state mental hospitals in Texas: Legislative primer. Retrieved from www.lbb.state.tx.us/HHS/Managing%20and%20Funding%20State%20Mental%20Hospitals%20in%20Texas%20-%20Legislative%20Primer.pdf

Forensic Patient Population in State Hospitals

According to DSHS, the forensic population in state hospitals is increasing. Some forensic patients who are in state hospitals for competency restoration have been accused of minor crimes such as trespassing and misdemeanor assault. In FY 2010, the total number of beds at state hospitals was 2,461 including 1,558 civil beds and 903 forensic beds.[103]

Figure 34 shows the number of civil and forensic beds at each state mental hospital in FY 2010.

Figure 34. Civil and Forensic Beds at State Hospitals in Texas, FY 2010



Source: Texas Legislative Budget Board. (February 2011). Managing and funding state mental hospitals in Texas: Legislative primer. Retrieved from www.lbb.state.tx.us/HHS/Managing%20and%20Funding%20State%20Mental%20Hospitals%20in%20Texas%20-%20Legislative%20Primer.pdf

Forensic commitments generally involve longer lengths of stays in the state hospitals. According to DSHS, the average stay for a non-forensic patient is less than 30 days compared to 30 to 90 days for forensic patients. As of June 2012, there were 218 people on the forensic waiting list for state hospital forensic beds.[104] The wait for a forensic bed can be as long as six months in jail for some nonviolent offenders needing inpatient services. These long wait periods can have a significant negative impact on the forensic patient's mental health and overall health conditions.[105]

Forensic Bed Capacity

Delays in receiving timely restoration and mental health services likely contribute to re-offending and cycling back into the judicial system.[106] Beds that have historically been available for civil commitments are increasingly being used by individuals needing forensic commitment and restoration services. Due to extended jail stays for some individuals, legislation was passed during the 82nd legislative session (House Bills 748 and 2725) limiting incarceration time to the maximum time for the crime charged.

In January 2012, a Travis County Judge Orlinda L. Naranjo ordered DSHS to make beds available to detainees considered incompetent to stand trial within 21 days of notice to DSHS.[107] The ruling was in response to a lawsuit filed by Disability Rights Texas against DSHS in February 2007 to protest the excessive amount of time between a criminal defendant being found incompetent to stand trial and the time of admission to a state hospital. The state has appealed the ruling, and in the meantime DSHS is identifying opportunities to increase the availability of restoration services in both inpatient and outpatient settings to abide by the court's decree. Potential options include funding additional beds at existing sites, contracting for additional beds outside of the state hospital system, developing lower level-of-care step-down units and expanding outpatient competency restoration services.

Maximum Security Bed Waitlists

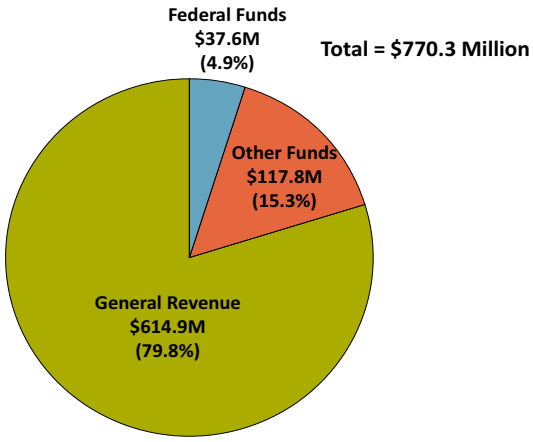
One barrier to admitting forensic patients to hospital restoration services more quickly is the limited maximum-security capacity in state hospitals. As of September 2012 there were approximately 98 individuals waiting for admission to a maximum-security bed. Rusk State Hospital opened 60 more beds in June 2012 and North Texas State Hospital opened 40 new beds in July 2012.

In addition to maximum-security beds, transitional forensic beds are needed to allow for patients to transition out of maximum security. DSHS is also contracting for 90 civil beds in private hospitals freeing up additional beds in state facilities for forensic patients.[108]

Funding State-Owned Psychiatric Hospitals in Texas

In 2009, the 81st Legislature appropriated a total of $770.3 million in all funds and approximately 7,550 full-time-equivalent (FTE) positions for state hospitals for the FY 2010 – 2011 biennium. Figure 35 shows the type of funding and percentage of state appropriations for state hospitals during this period. Appropriations increased by $29.7 million to maintain the FY 2007 bed capacity.[109]

Figure 35. State Hospital Funding by Method of Finance, FY 2010 – 2011 Biennium



Source: Texas Legislative Budget Board. (February 2011). Managing and funding state mental hospitals in Texas: Legislative primer. Retrieved from **www.lbb.state.tx.us/HHS/Managing%20and%20Funding%20State%20Mental%20Hospitals%20in%20Texas%20-%20Legislative%20Primer.pdf**

Institutions for Mental Diseases Exclusion

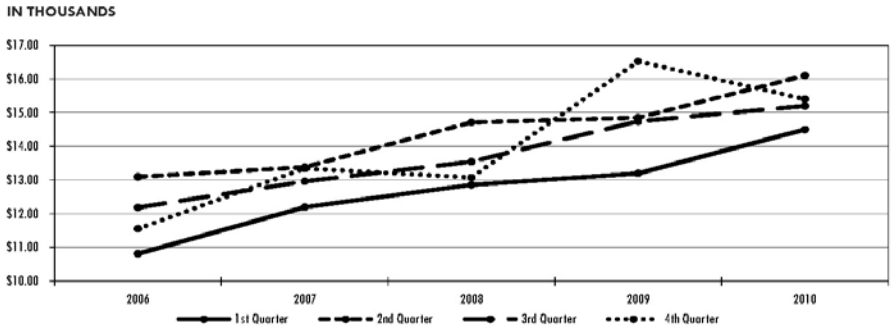
Under current federal law, Medicaid funding to state hospitals can only be used to serve children and adolescents age 21 and younger and eligible adults over the age 65. Due to this federal policy, state general revenue is the primary funding source for state hospital services for adults between the ages of 22 and 64.

This is because all state hospitals are subject to the institutions for mental diseases (IMD) exclusion. The IMD exclusion in Section 1905 of the Social Security Act defines an IMD as a hospital, nursing facility or other institution with more than 16 beds primarily engaged in providing diagnosis, treatment or care of persons with mental health conditions, including medical attention, nursing care and related services for individuals under 22 years or over 64 years of age. The IMD exclusion policy has been in place since Medicaid was enacted in 1965.

Cost Considerations

In the past five years, average cost per patient increased at state hospitals. Figure 36 shows the average cost per patient served in all state hospitals for each quarter of FY 2006 to FY 2010. The yearly average cost per patient served was $11,912 in FY 2006, $12,971 in FY 2007, $13,547 in FY 2008, $14,828 in FY 2009 and $15,325 in FY 2010. The average cost per patient increased by $3,413 or 27% from FY 2006 to FY 2010.[110]

Figure 36. Average Cost Per Patient Served in State Hospitals in Texas, FY 2006 to FY 2010



Source: Texas Legislative Budget Board. (February 2011). Managing and funding state mental hospitals in Texas: Legislative primer. Retrieved from www.lbb.state.tx.us/HHS/Managing%20and%20Funding%20State%20Mental%20Hospitals%20in%20Texas%20-%20Legislative%20Primer.pdf

Utilization and Costs

As shown in Figure 37, more than 14,000 individuals were served in state hospitals in FY 2010. The average cost per person was approximately $16,000 while the average cost per bed per day was just over $400. The average length of stay was 57 days.

Figure 37. Utilization and Costs for State Hospitals

	FY 2011
Total served	14,187
Average cost per person	$15,892
Average cost per bed per day	$400
Average length of stay	57 days

Sources: Texas Department of State Health Services. (August 16, 2012). FY 2014-2015 Legislative appropriations request – volume 1. Retrieved from www.dshs.state.tx.us/Layouts/ContentPage.aspx?PageID=53931&id=8589950368&terms=appropriations+budget and Texas Department of State Health Services, State Hospitals Section. (2011). Statewide Performance Indicators 4th quarter FY 2011. Retrieved from www.dshs.state.tx.us/mhreports/PIMHpub_2.shtm

Quality of Care

DSHS monitors inpatient quality and performance in several areas based on the RDM framework. The following two indicators are representative of data captured on a regular basis.

Figure 38. Selected Quality of Care Measures for State Mental Hospitals

	FY 2010	FY 2011
Percent of persons served at state facilities with stabilized or improved outcomes	99%	99%
Percent of forensic commitments returned to the community within 31-90 days	54%	45%

Source: Texas Department of State Health Services. (October 10, 2011). *Behavioral health data book, FY 2011, fourth quarter* [PowerPoint slides]. Retrieved from www.dshs.state.tx.us/mhsa/databook/

Additional quality measure can be found in the Behavioral Health Data Book at **www.dshs.state.tx.us/mhsa/databook/**. With the 1115 transformation waiver focusing in part on reduced hospital admissions, a number of state hospital quality measures will likely be monitored closely in the future.

Texas Department of Family and Protective Services

Trauma inflicted by experiencing violence (physical, psychological or sexual abuse) or chronic neglect has a profound effect on children.[111] The effects of trauma can last a lifetime; adults who experience significant childhood abuse and family discord as children have a higher incidence of physical and behavioral health problems.[112] In 2009, the 81st Texas Legislature enacted HB 1151, requiring eight hours of trauma-informed care training for Child Protective Services (CPS) case workers and supervisors, two hours for other CPS staff, and three hours for direct care givers.[113]

Trauma-related mental health and substance use conditions are highly prevalent in children in CPS custody nationally and in Texas. Among children in custody who were sexually abused, 60% were diagnosed with post-traumatic stress, as were 42% of children who had been physically abused.[114] A 2003 national study found that 48% of children reported to state CPS agencies for investigation of abuse or neglect had clinically significant emotional or behavioral conditions.[115] Among adolescents, 48% had conditions that persisted into early adulthood. Only one-fourth of these children had received mental health care in the year prior to the abuse investigation.[116] Similar difficulties were found among children younger than age 6, 46% of whom had behavioral or developmental difficulties.

Overview of Child Protective Services Delivery System

The Texas Department of Family and Protective Services (DFPS) operates the child protective services delivery system. In FY 2011, there were 31,092 Texas children in foster care.[117]

Since 2004, CPS has been striving to reduce the disproportionate representation of African American and Native American children in the child welfare system. This represents an important cultural shift within DFPS. Each DFPS region has at least one dedicated member and 14 regional advisory committees promoting collaborative partnerships to address disproportionality. These partnerships include other organizations and institutions that can affect the lives of children and families, such as school districts, juvenile probation, the faith-based community, the judiciary, law enforcement, service providers, foster parents and many others.

Policy Concerns:

- Implementation of system re-design and the impact on access to mental health services
- Parental relinquishment of a child to obtain critical mental health services
- Children in long term facilities
- Transitioning youth living with mental illness

Figure 39. Number and Percent of Children in Texas Child Protective Services, by Race/Ethnicity (2011)

	Total Number	% Hispanic	% White	% African American
State child population	6,663,942	48%	36%	12%
Open CPS cases	70,196	49%	26%	21%
CPS confirmed victims	65,948	45%	31%	20%

Source: Texas Department of Family and Protective Services. (2011). Annual report and data book. Retrieved from www.dfps.state.tx.us/documents/about/Data_Books_and_Annual_Reports/2011/Combined11.pdf

As shown in Figure 39, African American children comprise only 12% of the state's population of children, but they represent 21% of open CPS cases and 20% of CPS confirmed victims.

DFPS annually reports information on children in foster care related to mental health and substance use. FY 2011 data show that among children and youth in the child welfare system:

- 17% of children ages 0 to 17 in custody had emotional disturbance or mental health conditions.[118]
- 1,509 children received treatment in psychiatric treatment centers in FY 2011.[119]
- 10% of children in adoptive homes had emotional disturbance.[120]

Utilization of Mental Health and Substance Use Services

Children in foster care receive physical health and behavioral health services through Medicaid STAR Health, a managed care organization delivery model. In FY 2011, 49,106 children were enrolled in STAR Health.[121] The HHSC FY 2010 external quality review of STAR Health determined that 78% of children in foster care used a behavioral health service that year.[122]

The top three STAR Health mental health services used by children in foster care in FY 2011 were:

- Individual psychotherapy
- Psychological testing
- Psychiatric diagnostic interview

Foster Care Redesign

Since 2010, DFPS has been working to redesign the foster care system with a stated goal of improving physical and mental health care without an increase in state spending.[123] In August 2011, the department issued a request for proposals to pilot the redesigned system. A primary objective was to pilot two sites where contractors are responsible for developing and providing a full continuum of services for children in foster care, including various behavioral health services.

The department is undertaking redesign efforts in part to reduce the emotional and psychological trauma children often experience when they come into the Child Protective Services system. To accomplish this, performance goals for the redesign were developed. They include the following:

- First and foremost, all children and youth are safe from abuse and neglect in their placement.
- Children and youth are placed in their home communities.
- Children and youth are appropriately served in the least restrictive environment that supports minimal moves.
- Connections to family and others important to the child are maintained.
- Children and youth are placed with their siblings.
- Services respect the child's culture.

- To be fully prepared for successful adulthood, youth are provided opportunities, experiences and activities similar to those experienced by their peers who are not in foster care.
- Youth are provided opportunities to participate in decisions that impact their lives.[124]

While the initial intent was to contract with two entities in two parts of the state, the department will initially contract with only one entity to manage all foster care in one pilot region. The selected contractor will oversee care to foster children in rural regions 2 and 9, which is Abilene and San Angelo.

Institutional Residential Services

Prior to placing a child in foster care, the court is required to consider temporary placement with a relative.[125] If this option is not available or appropriate, the child may be placed in 1) a foster home with foster parents, 2) a general revenue operations (GRO) facility, or 3) a residential treatment center (RTC).[126] A GRO is a congregate care facility that provides residential services for 13 or more children up to the age of 18 years. GROs are licensed by DFPS and include long-term residential facilities as well as emergency shelters in which children may be placed for up to 30 days until a longer-term placement can be found. RTCs provide care and treatment services exclusively for children with emotional disturbance or mental health issues. RTCs serve 13 or more children up to the age of 18 years. As of August 2011, 1,509 children were living in RTCs.[127]

Parental Relinquishment of Custody

A 1999 study by the National Alliance on Mental Illness (NAMI) of parents with children experiencing "serious emotional illness" found that 20% of respondents reported giving up legal custody of a child with serious mental illness to the state in order to access intensive mental health treatment.[128] A 2004 Virginia study found that one in four children in foster care were in placement because their parents had relinquished custody to access otherwise unavailable or unaffordable mental health treatment.[129]

These are children with serious mental health conditions and their treatment is often expensive due to the need for temporary residential treatment. Some parents lack insurance altogether and others have insufficient coverage. Requiring parents to relinquish custody of their child in order to obtain necessary mental health treatment is not in the best interest of the child, traumatizes the child and family, and is costly to the state.

In addition to the trauma it causes parents and children, parental relinquishment of custody to obtain critically needed mental health services creates additional problems in Texas. When parents relinquish custody of their child to the state under these circumstances, they are deemed to have "refused to accept parental responsibility," which is considered a form of neglect.

State child welfare officials in 19 states and county juvenile justice officials in 30 counties who responded to surveys estimated that in FY 2001, parents in their jurisdictions placed over 12,700 children—mostly adolescent males—into the child welfare or juvenile justice systems so that these children could receive mental health services.

Source: U.S. General Accounting Office. (2003, April). *Child welfare and juvenile justice: Federal agencies could play a stronger role in helping states reduce the number of children placed solely to obtain mental health services* (GAO-03-397). Washington, D.C.: U.S General Accounting Office. Retrieved from http://www.gao.gov/new.items/d03397.pdf

The parents' names are then added to the Texas child abuse/neglect registry. This can have serious consequences for parents, especially those who are teachers, child care workers or who work in some capacity with children, as they become at risk of losing their jobs.

DFPS is not able to provide specific data on the number of children relinquished for the sole purpose of obtaining intensive mental health services, but it is estimated to be several hundred children per year.[130] While the YES waiver discussed in the DSHS section was developed and designed to reduce the need for relinquishment, YES waiver services are currently available in only three Texas counties.

Preparation for Adult Living Program

The Preparation for Adult Living (PAL) program is designed to prepare older youth in substitute care for their departure from the child protective services system. PAL policy requires that all youth aged 16 and older receive preparation for adult living, although any youth age 14 or older may receive PAL services if funding is available. Services are individualized with specific plans and training developed based on the results of an independent living skills assessment. Training covers the areas of personal and interpersonal skills, job skills, housing and transportation, health, planning for the future and money management. In addition, a number of optional services are provided for transitioning youth based on need and availability of funding, such as vocational assessment and training, preparation for college entrance exams, counseling and volunteer mentoring. PAL participants also are eligible to receive a transitional living allowance once they leave care. All youth in DFPS care on or after their 18th birthday may attend state-supported vocational schools, colleges and universities with tuition and fees waived.[131] The average number of individuals served through the PAL program and the monthly cost for serving them is detailed below in Figure 40.

Figure 40. Utilization/Cost for Preparation for Adult Living (PAL) Services

	Expended 2011	Estimated 2012	Budgeted 2013
Average number of youth served per month	1,423	1,440	1,343
Average monthly cost per youth served	$557.37	$543.04	$543.04

Source: Texas Department of Family and Protective Services. (August 16, 2012). Legislative appropriations request for FY 2014 - 2015, volume I. Retrieved from www.dfps.state.tx.us/documents/about/Financial_and_Budget_Information/14-15/14-15_LAR_Vol1.pdf

Prevention and Early Intervention

Through its Division of Prevention and Early Intervention (PEI), DFPS contracts for programs designed to address the needs of at-risk children and families, reduce the risk of child abuse and neglect, and support successful transitions to adulthood.[132] PEI programs are administered through contracts with local community agencies or organizations and not all services are available in all Texas communities.

Funding for several prevention programs is shown in Figure 41. The legislative appropriations bill funds DFPS prevention programs. Although in 2011 HB 1 proposed to cut the budget item for "Other At-Risk Prevention Programs," however an amendment was added to restore $4.6 million in general revenue to the program.[133]

Figure 41. Cost for Prevention and Early Intervention (PEI) Programs

Program	Expended 2011	Estimated 2012	Budgeted 2013
Services to at-risk youth	$19,423,201	$18,283,303	$18,283,304
Community youth development	$6,115,709	$5,039,300	$5,039,300
Texas Families: Together and Safe program	$2,982,184	$2,610,039	$2,610,039

Source: Texas Department of Family and Protective Services. (August 16, 2012). Legislative appropriations request for FY 2014 - 2015, volume I. Retrieved from www.dfps.state.tx.us/documents/about/Financial_and_Budget_Information/14-15/14-15_LAR_Vol1.pdf

Services to At-Risk Youth

Through contracts with community agencies, the Services to At-Risk Youth (STAR) program offers family crisis intervention counseling, short-term emergency residential care, and individual and family counseling to youth up to age 17 who experience conflict at home, have been truant or delinquent, or have run away. These services are available in all 254 Texas counties. Each STAR contractor also provides universal child abuse prevention services, ranging from local media campaigns to informational brochures and parenting classes.[134] The average number of individuals served through this program and the monthly cost for serving them is detailed below.

Figure 42. Utilization/Cost for Services to At-Risk Youth (STAR) Program

	Expended 2011	Estimated 2012	Budgeted 2013
Average number of youth receiving STAR services per month	6,438	6,169	5,801
Average monthly DFPS cost per youth served	$246.38	$246.98	$262.62

Source: Texas Department of Family and Protective Services. (August 16, 2012). Legislative appropriations request for FY 2014 - 2015, volume I. Retrieved from www.dfps.state.tx.us/documents/about/Financial_and_Budget_Information/14-15/14-15_LAR_Vol1.pdf

Community Youth Development

The Community Youth Development program contracts with community organizations to develop juvenile delinquency prevention programs in zip codes that have a high incidence of juvenile crime. Approaches used by communities to prevent delinquency have included mentoring, youth employment programs, career preparation and alternative recreation activities. Communities prioritize and fund specific prevention services that are identified as needed locally.[135] The average number of individuals served through this program and the monthly cost for serving them is shown below.

Figure 43. Utilization/Cost for Community Youth Development Services

	Expended 2011	Estimated 2012	Budgeted 2013
Average number of youth served per month	6,158	5,782	5,535
Average monthly FPS cost per youth served	$82.77	$72.62	$75.87

Source: Texas Department of Family and Protective Services. (August 16, 2012). Legislative appropriations request for FY 2014 - 2015, volume I. Retrieved from www.dfps.state.tx.us/documents/about/Financial_and_Budget_Information/14-15/14-15_LAR_Vol1.pdf

Texas Families: Together and Safe

The Texas Families: Together and Safe program funds community-based programs designed to alleviate stress and promote parental competencies and adoption of behaviors that will increase the ability of families to successfully nurture their children and work toward family self-sufficiency. These services are available in 11 areas of the state that cover 30 counties. The program goals are to:

- Improve and enhance access to family support services.
- Increase the efficiency and effectiveness of community-based family support services.
- Enable children to remain in their own homes by providing preventive services.
- Increase collaboration among local programs, government agencies and families.[136]

The average number of individuals served through this program and the average monthly cost is shown below.

Figure 44. Utilization/Cost for Texas Families: Together and Safe Services

	Expended 2011	Estimated 2012	Budgeted 2013
Average number of families served	573	615	597
Average monthly cost per family served	$433.71	$353.60	$364.21

Source: Texas Department of Family and Protective Services. (August 16, 2012). Legislative appropriations request for FY 2014 - 2015, volume I. Retrieved from www.dfps.state.tx.us/documents/about/Financial_and_Budget_Information/14-15/14-15_LAR_Vol1.pdf

Community-Based Child Abuse Prevention

The Community-Based Child Abuse Prevention program provides federal grants to develop and support local partnerships to increase community awareness of existing prevention services, strengthen community and parental involvement in child abuse prevention efforts, and encourage families to engage in services that are already available. This funding has supported six communities in the development of community partnerships. In addition, it has funded short-term respite services in two communities and an infant mortality prevention program in one community. The model places a high priority on parental involvement and participation in the design, implementation and evaluation of community-based programs and activities designed to prevent child abuse and neglect.[137]

The total costs to provide child abuse prevention grants to community-based organizations is provided in Figure 45.

Figure 45. Cost for Child Abuse Prevention Grants to Community-Based Organizations

	Expended 2011	Estimated 2012	Budgeted 2013
Total expense	$1,207,345	$3,950,277	$3,946,954

Source: Texas Department of Family and Protective Services. (August 16, 2012). Legislative appropriations request for FY 2014 - 2015, volume I. Retrieved from www.dfps.state.tx.us/documents/about/Financial_and_Budget_Information/14-15/14-15_LAR_Vol1.pdf

Texas Runaway and Youth Hotlines

The toll-free Texas Runaway Hotline (1-888-580-HELP) and Texas Youth Hotline (1-800-98-YOUTH) offer crisis intervention, telephone counseling and referrals to troubled youth and families. A workforce of about 60 volunteers answers phone lines. Callers raise a variety of situations including family conflict, delinquency, truancy, and abuse and neglect. The program increases public awareness of these hotline resources through television, radio, billboards and other media efforts. Hotline telephone counselors respond to about 40,000 calls annually.[138] The total annual expense for operating the hotlines is detailed in Figure 46.

Figure 46. Texas Runaway and Youth Hotlines

	Expended 2011	Estimated 2012	Budgeted 2013
Total expense	$268,996	$256,571	$256,950

Source: Texas Department of Family and Protective Services. (August 16, 2012). Legislative appropriations request for FY 2014 - 2015, volume I. Retrieved from www.dfps.state.tx.us/documents/about/Financial_and_Budget_Information/14-15/14-15_LAR_Vol1.pdf

Statewide Youth Services Network

The Statewide Youth Services Network program supports statewide networks of community-based prevention programs that provide evidence-based juvenile delinquency prevention services to address conditions resulting in negative outcomes for children and youth. The program is focused on youth ages 10 through 17 and offers services in each DFPS region.[139] The total expense for the network is detailed in Figure 47.

Figure 47. Cost for Statewide Youth Services Network

	Expended 2011	Estimated 2012	Budgeted 2013
Total expense	$1,985,794	$1,525,000	$1,525,000

Source: Texas Department of Family and Protective Services. (August 16, 2012). Legislative appropriations request for FY 2014 - 2015, volume I. Retrieved from www.dfps.state.tx.us/documents/about/Financial_and_Budget_Information/14-15/14-15_LAR_Vol1.pdf

Community-Based Family Services

The Community-Based Family Services program serves families that CPS investigates but is unable to substantiate allegations of abuse or neglect. The program provides community and evidence-based services to prevent child abuse and neglect. Services include home visitation, case management and additional social services to provide a safe and stable home environment. These services are currently offered in Bexar and Travis counties.[140] The total expense for these services is detailed in Figure 48.

Figure 48. Cost for Community-Based Family Services

	Expended 2011	Estimated 2012	Budgeted 2013
Total expense	$448,074	$765,576	$765,576

Source: Texas Department of Family and Protective Services. (August 16, 2012). Legislative appropriations request for FY 2014 - 2015, volume I. Retrieved from http://www.dfps.state.tx.us/documents/about/Financial_and_Budget_Information/14-15/14-15_LAR_Vol1.pdf

Special Initiatives

Special initiatives for prevention and early intervention include child abuse prevention media campaigns, development and distribution of an annual child abuse prevention kit, statewide surveys of prevention and early intervention service providers, and support of the annual Partners in Prevention Training Conference. These initiatives include:

- Help for Parents, Hope for Kids: Child abuse prevention campaign and calendar.[141]
- Room to Breathe: Safe sleeping practices for infants .[142]
- Watch Kids Around Water: Water safety for children at home and outdoors.[143]
- Partners in Prevention Training Conference: Annual conference for parents, agency workers, mental health professionals, and others who work with children and youth. [144]

Department of Aging and Disability Services

The Texas Department of Aging and Disability Services (DADS) is responsible for providing long-term services and supports for aging Texans, as well as persons with physical disabilities and persons with intellectual and other developmental disabilities.

While behavioral health conditions can affect anyone, there is evidence that behavioral health conditions, especially depression, often co-occur with other disabilities. This may be due to psychological stress related to a disability, social isolation, trauma, institutionalization and other factors. [145, 146]

Policy Concerns:

- Addressing the mental health needs of people with disabilities
- Expansion of positive behavior supports for people with disabilities
- Community services for individuals with disability and co-occurring mental illness and challenging behaviors
- Implementation of trauma-informed care practices
- Multi-year waiting lists for services

Services and Programs for Aging Individuals and People with Disabilities who Have Co-occurring Behavioral Health Conditions

DADS serves persons who are aging, people with physical disabilities and people with intellectual and other developmental disabilities including those who have co-occurring behavioral health conditions. Programs and services include Medicaid waivers and non-waiver programs such as day habilitation, safety-net community services and community attendant services. Individuals with disabilities and co-occurring behavioral health conditions also may be served in residential facilities such as intermediate care facilities, state supported living centers and nursing facilities. Figure 49 shows the percentage of persons with disabilities and co-occurring behavioral health conditions receiving services in the various DADS programs.

Figure 49. Percentage of Persons Enrolled in DADS Waivers with a Behavioral Health Diagnosis (FY 2010—FY 2012)

	FY 2010	FY 2011	FY 2012
Community-based alternatives	19%	16%	13%
Community Living Assistance and Services Supports (CLASS)	21%	21%	21%
Deaf-blind with multiple disabilities	10%	10%	10%
Home & Community-based Services (HCS)	36%	36%	36%
Medically dependent children's program	22%	33%	38%
Texas Home Living Waiver (TxHmL)	29%	26%	25%

Source: Texas Department of Aging and Disability Services. (August 16, 2012). Data Request.

The costs for providing the programs listed above are detailed in Figure 50.

In the DADS section of this guide, the term "disability" is used to refer to people with physical disabilities and people with intellectual and other developmental disabilities. It should be noted that some mental health conditions can constitute a disability under some program eligibility criteria and legal protections even though the term is not typically used when referring to people with behavioral health conditions. People living with mental illness often prefer not to be identified as having a disability while people with physical disabilities and people with intellectual and other developmental disabilities often prefer the terminology.

Figure 50. Total Cost of Selected Programs Serving Individuals with Disabilities

(Data on costs for behavioral health services in these programs is not available)

	Expended 2011	Estimated 2012	Budgeted 2013
Community-based alternatives	$438,890,245	$257,204,469	$162,844,245
Community Living Assistance and Services Supports (CLASS)	$192,726,160	$196,337,036	$195,682,608
Deaf-blind with multiple disabilities	$7,536,630	$7,881,621	$7,946,688
Home and Community-based Services (HCS)	$808,171,460	$816,518,516	$847,287,096
Medically dependent children's program	$43,579,249	$41,750,047	$41,476,500
Texas Home Living Waiver (TxHmL)	$7,427,958	$39,217,936	$55,084,800
State supported living centers	$661,913,217	$669,936,418	$660,931,644

Source: Texas Department of Aging and Disability Services. (August 14, 2012). 2A. Summary of base request by strategy – 83rd Regular Session, agency submission, version 1 [Data file]. Retrieved from http://147.80.232.21/lar/2014_15/VolumeI/SummariesofRequest/SummaryOfBaseRequestByStrategy.pdf

Prevalence of Mental Health or Substance Use Among Persons with Intellectual and Developmental Disabilities and Seniors

Among persons with intellectual and developmental disabilities, the prevalence of co-occurring mental health and substance use conditions is substantial, estimated to be as high as 33% with some studies finding much higher rates.[147] The rate of behavioral health conditions among children in Texas state supported living centers in FY 2010 was much higher, with 78% of the children and youth having co-occurring conditions.[148]

Persons who are aging also experience behavioral health conditions. A July 2012 report by the Institute of Medicine warned of an upcoming "silver tsunami" of unmet mental health and substance use treatment needs among the senior population.[149] Approximately 20% of the current elderly population has some form of behavioral health condition, most commonly depression, alcoholism or dementia-related behavioral or psychiatric symptoms.[150] An estimated two million seniors in the United States have serious mental illness.[151]

Barriers to Accessing Behavioral Health Care Services

People with Disabilities

While the number of individuals with disabilities needing mental health services is significant, many mental health professionals do not have the experience, training or skills needed to address their mental health needs. Diagnosing and treating mental illness in people with disabilities can be difficult for professionals unfamiliar with the disabilities. For example, persons with intellectual or developmental disabilities may have limited verbal communication skills or may have difficulty understanding complex issues, which therefore requires specialized skills for conducting an effective mental health evaluation. Because of the difficulty in assessing and diagnosing behavioral challenges in people with disabilities, the behaviors are often attributed to the disability rather than to an underlying mental health condition.

In addition, participation in behavioral health treatment may be more complicated or inaccessible for persons with intellectual and development disabilities or physical disabilities due to the need for special accommodations, such as accessible service locations, transportation and use of technology to deliver services.

Seniors

A significant number of aging Texans and people with disabilities living with mental illness reside in nursing homes. In 2005, 27% of Texas nursing home residents had a behavioral health condition, 2.5% of whom had a serious mental illness such as major depression, schizophrenia or bipolar disorder.[152] Nationally, the average age of persons admitted to nursing facilities is 77 years while the average age of admission for persons with serious mental illness is 62 years.[153]

DADS Initiatives to Improve Access to Behavioral Health Services

Promoting Independence Initiative

The Texas Promoting Independence Initiative began in January 2000 in direct response to the U.S. Supreme Court ruling in Olmstead v. L.C., in which the court ruled that states must provide community-based services for persons with disabilities under the following conditions:

- The person would otherwise be entitled to institutional services.
- The state's treatment professionals deem community-based placement to be appropriate.
- The affected person agrees to such treatment.
- The placement can be reasonably accommodated given the resources available to the state and the needs of others who are receiving state-supported disability services.[154]

As part of the Promoting Independence Initiative, a number of supports are available to help individuals remain in or return to their communities of choice, including the Money Follows the Person program for nursing home residents, described below.

In addition, statewide relocation assistance, housing opportunities and community transition teams are available to assist nursing facility residents in their transition to community-based services. Unfortunately, similar relocation services are not currently available to individuals leaving state psychiatric facilities. In an effort to address this service gap, DSHS has submitted a proposal to DADS to use federal Balanced Incentive Program (BIP) funds to develop a pilot project for relocation services for individuals with serious mental illness. More information on these programs can be found on the Texas Department of Aging and Disability Services website, **www.dads.state.tx.us/providers/pi/index.html.**

Money Follows the Person Program

Among the many DADS initiatives impacting individuals with co-occurring conditions, DADS participates in a federally funded national demonstration program known as Money Follows the Person. This program makes it possible for persons on Medicaid living in institutional settings such as nursing homes to transition to community-based

services and supports. Since the inception of the program in Texas, more than 21,000 individuals have transitioned from nursing homes to community living with supports and services.[155] The age span of individuals taking advantage of the Money Follows the Person program ranges from less than one to more than 100 years old.

The age span of individuals taking advantage of the Money Follows the Person program ranges from less than one to more than 100 years old.

In 2008, a pilot to help persons with complex health and behavioral health conditions was added to the program. The pilot, administered by DSHS, adds an evidence-based intervention called cognitive adaptation training and substance use services to the array of services available to help persons with serious mental illness or substance use conditions who reside in nursing homes transition to living in the community.[156]

Long-Term Services and Supports

DADS is responsible for the administration and regulation of long-term services and supports. Many of these programs provide needed services to people with disabilities and co-occurring behavioral health challenges.

Medicaid 1915(c) Waiver Services

DADS administers the 1915(c) Medicaid waiver programs designed to provide community supports and services to individuals eligible for institutional care. These waivers were developed to prevent the institutionalization of people with disabilities. Community care not only is typically less expensive than institutional care but also is preferred by most individuals and their families.

Persons with co-occurring developmental disabilities and behavioral health conditions are primarily served through three Medicaid waiver programs: Home and Community-Based Services (HCS), Community Living Assistance and Support Services (CLASS) and Texas Home Living (TxHmL). Older Texans and people with disabilities needing long-term services and supports qualify for Medicaid waiver services if their income is less than three times the social security income limit (approximately 220% of the federal poverty level) and if they otherwise meet functional eligibility criteria for institutional care in nursing facilities or intermediate care facilities.

Access to these waiver services, however, is not an entitlement and each program currently has a significant wait list (or "interest list"). The wait time for services varies by program but ranges from three to more than 10 years.

Figure 51 provides basic information about eligibility and services for these three primary waivers for persons with intellectual and other developmental disabilities.

Figure 51. Community-Based Waiver Eligibility and Behavioral Health-Related Services for Persons with Intellectual and Developmental Disabilities

	Home and Community-Based Services (HCS)	Community Living Assistance and Support Services (CLASS)	Texas Home Living Waiver (TxHmL)
Eligibility	Individuals of any age with an intellectual disability diagnosed before age 22. Must have an IQ score below 70 or a related condition and an IQ score below 75. Must have functional limitations that qualify for intermediate care facility services. Individual plan of care is capped.	Individuals of any age with a primary disability other than intellectual disability that originated before age 22 and affects the person's ability to function in daily life. Must have functional limitations that qualify for intermediate care facility services. Individual plan of care is capped.	Individuals of any age with an IQ below 70 or a related condition with an IQ below 75. Must have functional limitations that qualify for intermediate care facility services. Individual plan of care cannot exceed $17,000.

Behavioral Health Services and Supports Included in the Waiver Service Array	• Case management
	• Consumer-directed services
	• Behavioral support, including social work and psychology
	• Residential assistance including:
	  ○ supported home living
	  ○ foster/companion care
	  ○ supervised living (group home)
	  ○ residential support
	• Respite
	• Day habilitation
	• Supported employment
		• Case management
		• Consumer-directed services
		• Habilitation
		• Psychological and behavioral support services
		• Respite
		• Specialized therapies such as aquatic, music, recreational
			• Specialized therapies
			• Behavioral support
			• Community support
			• Respite
			• Day habilitation
			• Supported employment
			• Consumer-directed services

Sources: Texas Department of Aging and Disability Services. (2012). Reference Guide 2012. Retrieved from www.dads.state.tx.us/news_info/budget/index.html and Texas Department of Aging and Disability Services. (n.d.). Website FAQs and fact sheets. Retrieved from www.dads.state.tx.us/services/faqs-fact/index.html

Figure 52 below provides projected utilization and costs estimates for FY 2012 for these three major waiver programs that DADS administers.

Figure 52. Utilization and Costs for DADS Waivers

Waiver	FY 2012 Projected Number Served (not limited to persons with behavioral health conditions)	June 2012 Interest List	FY 2012 Projected Average Cost/Month
Home and Community-Based Services (HCS)	19,860	52,676	$3,424
Community Living Assistance and Support Services (CLASS)	4,664	38,258	$3,509
Texas Home Living Waiver (TxHmL)	4,200	Part of the HCS interest list	$778

Sources: Texas Department of Aging and Disability Services. (2012, May). Interest list and waiver caseload summary archive calendar year 2012. Retrieved from www.dads.state.tx.us/services/interestlist/ and Texas Department of Aging and Disability Services. (July 2012). July Monthly Financial Report. Retrieved from cfoweb.bdm.dhs.state.tx.us/MonthlyFinancials/default.asp

Role of Local Mental Health Authorities in Connecting People to Waiver Services

Local authorities (previously referred to as local mental retardation authorities), also referred to as community centers, serve as the point of entry for the publicly funded waiver programs for persons physical, intellectual and developmental disabilities, as well as for general revenue safety-net services, intermediate care facilities, nursing facilities and state supported living centers. Depending on the program, local authorities have varying levels of responsibility for determining eligibility and enrollment, conducting assessments, developing service plans, coordinating and providing services, and maintaining wait lists. Local authorities are also responsible for permanency planning for individuals less than 22 years of age who live in an intermediate care facility, state supported living center, nursing facility or group home under the HCS waiver program.

Community-Based Alternatives Waiver

DADS administers a 1915(c) Medicaid waiver program called Community-Based Alternatives (CBA) that provides services to individuals with physical or medical disabilities. The CBA program is intended to be an alternative to nursing home care for older Texans and people with disabilities who would otherwise qualify for nursing facility care.

People over the age of 21 years who are elderly or have physical disabilities, qualify for a nursing facility level of care medically and financially, and require community services that can be provided within financial limits can choose to participate in the CBA waiver. This waiver allows people to live in their own homes, foster homes or assisted-living arrangements. Behavioral health-related services and supports include nursing services, occupational therapy, personal assistance, respite, prescription drugs (if not covered by Medicare) and transition assistance.

Non-Waiver Programs for Individuals with Intellectual Disabilities and Co-occurring Behavioral Health Conditions

Persons with intellectual disabilities and co-occurring behavioral health conditions may live in intermediate care facilities, which include small community homes, larger privately operated facilities, or in large state supported living centers.

DADS pays these facilities an all-inclusive rate that covers facility-related expenses, including basic psychological services. Medicare or Medicaid pay for other behavioral health services such as psychotropic medications.

The Texas program includes two categories of intermediate care facilities: state supported living centers and community-based intermediate care facilities.

State Supported Living Centers

State supported living centers (SSLCs) are large institutions that provide 24-hour residential services. Behavioral health treatment is a required service that must be provided by the facilities. The SSLCs are licensed and certified intermediate care facilities (ICFs) owned and operated by the state. SSLCs operate in 13 locations: Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, Rio Grande, San Angelo and San Antonio. Rio Grande State Center also is a licensed inpatient psychiatric hospital, serving persons with intellectual and developmental disabilities and mental illness. Individuals seeking placement in a state supported living center must meet both financial and functional eligibility requirements.

As part of a 2009 settlement agreement with the U.S. Department of Justice over conditions at SSLCs, DADS agreed to improve health, safety and quality of care for consumers living in them. The agreement included increased access to psychiatric care (including assessment, diagnosis and attention to polypharmacy prescribing practices), increased access to psychological services (including the use of evidence-based behavior management strategies), and improved policy and practices designed to reduce of the use of restraints.

Community-Based Intermediate Care Facilities

Intermediate care facilities (ICFs) services are optional services permitted in state Medicaid plans. Community-based ICFs can be licensed to provide services to people with intellectual disabilities or other developmental disabilities, sometimes referred to as related conditions. These facilities vary in size from six beds to over 100; most community-based ICFs are small, with eight or less beds, and are privately operated.

Figure 53 provides information on the eligibility for and services provided by community-based ICFs and SSLCs.

Figure 53. Institutional Settings Eligibility and Services for Persons with Intellectual and Developmental Disabilities and Behavioral Health Conditions

	Community-based Intermediate Care Facilities	State Supported Living Centers
Eligibility	• Have a diagnosis of intellectual disability with a full-scale IQ score of below 70 and an adaptive behavior level with mild to extreme deficits, OR • Have a full-scale IQ score of 75 or below and a primary diagnosis by a licensed physician of a related condition (manifest before age 22 years), and an adaptive behavior level with mild to extreme deficits, OR • Have a primary diagnosis of a related condition (manifest before age 22) diagnosed by a licensed physician regardless of IQ and an adaptive behavior level with moderate to extreme deficits, AND • Be in need of and able to benefit from the active treatment provided in the 24-hour supervised residential setting of an ICF.	• Meet ICF/ID eligibility requirements, AND • Have severe or profound intellectual and developmental disabilities, OR • Have intellectual and developmental disabilities and be medically fragile, OR • Have intellectual and developmental disabilities and behavioral challenges, OR • Represent a substantial risk of physical injury to self or others, AND • As an adult, be unable to provide for the most basic personal physical needs.[157]
Behavioral Health-Related Services and Supports	24-hour residential care and services that include: • physician services • behavioral health services • nursing • skills training • occupational, physical and speech therapies; • services to maintain connections between residents and their families/natural support systems	24-hour residential care and services that include: • physician and nursing services • behavioral health services • skills training • occupational therapies • vocational programs and employment • services to maintain connections between residents and their families/natural support systems

Source: Texas Department of Aging and Disability Services. (2012). Reference Guide 2012. Retrieved from **www.dads.state.tx.us/news_info/budget/index.html**

Figure 54 shows the projected number served and average net costs per month per client for the two ICF programs described above.

Figure 54. Utilization and Costs of Programs for Persons with Disabilities

Setting	FY 2012 Projected Number Served	FY 2012 Average Net Payment per Month per Client
Community-based intermediate care facilities	5,613	$4,359
State supported living centers	3,889	$13,899

Texas Department of Aging and Disability Services. (July 2012). July Monthly Financial Report. Retrieved from **cfoweb.bdm.dhs.state.tx.us/MonthlyFinancials/default.asp**

Guardianship Program

Guardianship is a legal method to protect individuals' wellbeing when they cannot protect themselves. A guardian is a court-appointed person or entity who makes decisions on behalf of an individual who lacks the capacity to make important life decisions. In a 2010 presentation to the Senate Health and Human Services Committee, DADS reported 1,213 active guardianships.[158]

The purpose of the guardianship program under Human Resources Code Section 161.101 is to provide guardianship services to:

- Incapacitated children upon reaching the age of 18 who have been in CPS conservatorship.
- Incapacitated adults age 65 or older, or between the ages of 18-65 with a disability, who were referred by Adult Protective Services (APS) following an investigation in which abuse, neglect, or exploitation was confirmed, and no other means of protecting the person is available and there is some indication the individual lacks capacity.
- Incapacitated individuals referred directly to the program by a court with probate authority under certain criteria established in statute or rule.[159]

Skilled Nursing Facilities

Texas nursing facilities provide institutional care for older Texans and people with disabilities whose medical condition requires skilled licensed nursing services. The nursing facility provides room and board, social services, medical supplies and equipment, over-the-counter drugs and personal needs items. Skilled behavioral health services are provided by psychiatrists and other medical and behavioral health professionals. Medications are paid for by Medicare or Medicaid, depending on individual coverage.

The institutionalization of individuals with mental illness in nursing homes is an important policy concern. Using nursing home minimum data set assessments from 2005, there were large cross-state variations in both the rates of mental illness among nursing home admissions and the estimated rates of nursing home admissions among persons with mental illness. Newly admitted individuals with mental illness were younger and more likely to become long-stay residents. Taken together, these results suggest that state-level mental health and nursing home factors may influence the likelihood of long-term nursing home use for persons with mental illness. [160]

Department of Assistive and Rehabilitative Services

The Texas Department of Assistive and Rehabilitative Services (DARS) provides early intervention services for children ages 0 to 3 with social and emotional delays, and vocational rehabilitation services for people with disabilities, including mental health or substance use conditions. The agency consists of three divisions: the Division for Early Childhood Intervention, the Division for Rehabilitative Services, and the Division for Blind Services. These divisions operate a number of programs for children and adults with disabilities.

Policy Concerns:

- ECI
  - Reduced funding for ECI services
  - Reduced eligibility requirements for ECI
  - Adequacy of services provided in ECI
- Vocational Rehab
  - Adequacy of transition specialists
  - Access to vocational rehab specialists with skills needed to assist people living with mental illness

Early Childhood Intervention for Children

The Early Childhood Intervention (ECI) program serves infants and toddlers ages 0 to 3 on a statewide basis. ECI serves eligible children with disabilities and developmental delays with funds from the Early Intervention Program for Infants and Toddlers. This grant program is authorized in Part C of the Individuals with Disabilities Education Act to assist states in operating a statewide early intervention program for infants and toddlers ages 0 to 3.[161] State general revenue funds are required to draw down federal funding. Recent changes to eligibility requirements were made as a result of FY 2012 – FY 2013 funding reductions, significantly reducing access to services. ECI expenditures during FY 2011 were approximately $189 million while the FY 2012 operating budget is approximately $163 million[162].

Eligibility for Services

To determine eligibility for ECI services, a team of at least two professionals from different disciplines performs a comprehensive evaluation of a child's abilities. Generally, eligibility is conditioned on a child meeting at least one of three criteria:[163]

- Medical diagnosis – Children with medical diagnoses that have a high probability of resulting in developmental delays. Thirteen percent of children qualify because of their medical diagnosis. For a list of diagnoses that qualify for ECI see **www.dars.state.tx.us/ecis/resources/diagnoses.asp**
- Auditory or visual impairment – Children with auditory or visual impairments as defined by the Texas Education Agency.[164]
- Developmental delay – Children with developmental delays of at least 25% that affect function in one or more areas of development. Eighty-seven percent of children qualify because they have a developmental delay or exhibit atypical development.

ECI evaluates a child for developmental delay using the Battelle Developmental Inventory, which includes an assessment of the child's social and emotional delays. Based on the results of this evaluation, ECI professionals and the child's family work as a team to develop an individual family service plan. The plan may include a range of services such as evaluation, service planning, family counseling and psychological and social

work services. Specialty mental health clinical services are available through referral for families with more extensive needs.

Utilization and Costs

Medical and health service providers refer 40% of all ECI recipients to the program. Parents, family and friends are the second greatest referral source at 26% of all ECI participants. The following figure identifies selected utilization and cost measures for ECI programs in FY 2011.

Figure 55. Utilization and Costs of Early Childhood Intervention Services

	FY 2011
Total children referred	77,706
Total children receiving eligibility determination	50,476
Total children receiving comprehensive services	59,092*
Average monthly cost per child	$513

*Some children receiving services in 2011 were deemed eligible in previous years.
Source: Texas Department of Assistive and Rehabilitative Services. (2011). Annual report 2011. Retrieved from www.dars.state.tx.us/reports/annual2011/2011_annual.pdf

The distribution of enrollment in the program by age is evenly split among the three key age groups, as follows:

- 0 to 12 months: 34%
- 13 to 24 months: 34%
- 25 to 36 months: 32%

The percentage of enrolled children using each of the major types of services is the following:

- Developmental services: 85%
- Speech language therapy: 49%
- Occupational therapy: 27%
- Physical therapy: 21%
- Nutrition: 11%
- Psychological/social work: 6%
- Family education/training: 4%
- Behavioral intervention: 3%
- Vision services: 2%
- Audiology: 2%

In FY 2010, 71% of infants and toddlers who entered early childhood intervention services and were below age expectations for social and emotional development improved functioning to a level near or comparable with same-age peers.[165] Additionally, 75% of enrolled children with below-age expectations for self-care and 76% of enrolled children with below-age expectations for the acquisition and use of knowledge and skills, including language and communication, showed an increase in rates of growth in these areas beyond what would have been expected without intervention.[166]

As a result of recent funding reductions for the program, DARS changed requirements from a "months-based" to a "percentage-based" calculation of a developmental delay and restructured family cost share, significantly reducing access to services. Children

will continue to receive an average of two hours of direct service per month, but this is below the level recommended by experts. Funding for FY 2010-2011 was $374 million and funding for FY 2012-2013 is $342 million.[167]

Disability Determination Services (DDS)

The federal Social Security Administration (SSA) operates two income stability programs for children and adults with disabilities. Social security disability insurance (SSDI) is governed by rules set out in Title II of the Social Security Act and covers workers age 18 to 65 who are disabled, disabled widows/widowers, and disabled adult children of workers. People earn eligibility for this program throughout their working lives by paying social security taxes. Approval for SSDI payments results in eligibility for Medicare coverage after a two-year waiting period. The second income program available is supplemental security income (SSI) governed by rules set out in Title XVI of the Social Security Act. SSI provides monthly stipends to qualifying children and adults under the age of 65. Once approved for SSI, participants are eligible for Medicaid.

Process for Admission and Eligibility

Admission to both programs is conditioned on the determination that an individual has a disability. Disability determination officers within DARS make the initial disability determination. The SSA makes the final admission decision and considers a more exhaustive set of eligibility criteria. Both SSI and SSDI are cash assistance programs. To be eligible for SSI, adults and children must meet strict financial and functional criteria. The federal monthly payment standard for SSI as of January 2012 is $698 per eligible individual and $1,048 per eligible individual with an eligible spouse.[168] Monthly benefits for SSDI are dependent on the social security earnings record of the worker.

Information on eligibility criteria can be found on the Social Security website at **www.ssa.gov**.

Utilization

Figure 56 shows statistics about the number of cases received and determined, along with program outcomes on the percent of initial disability cases allowed, average monthly reconsideration rate and accuracy against the SSA's final decision.

Figure 56. Utilization of Disability Determination Services in Texas

	2011
Total SSI and SSDI cases received	367,599
Total cases determined	366,676
Percent of initial disability cases allowed	38%
Average monthly reconsideration rate	14%
Accuracy with regards to ultimate SSA decision	97%

Sources: Texas Department of Assistive and Rehabilitative Services. (2011). Annual report 2011. Retrieved from **www.dars.state.tx.us/reports/annual2011/2011_annual.pdf** and Social Security Administration. (2012). SSA state agency monthly workload data. Retrieved from **www.socialsecurity.gov/disability/data/ssa-sa-mowl.htm**

Vocational Rehabilitation

According to a 2011 report from the U.S. Department of Health and Human Services, the employment rate for the general population is approximately 64.5%, with approximately 80% of employed individuals working full-time. The employment rate for people with

serious mental illness, however, is estimated to be around 22%, with approximately 12% working full-time.[169] Unemployment rates for the general population and for persons with disabilities are 8.7% and 15.0%, respectively.[170]

Research suggests that there may be "four types of barriers to employment among individuals with mental illness: (a) illness characteristics, (b) client characteristics, (c) access to services and appropriate mental health treatment, and (d) characteristics of the workplace and the labor market."[171] However, having meaningful employment can significantly impact recovery for people with mental illness by providing opportunities for community integration, increased independence and a better quality of life. The role DARS plays in supporting people living with mental illness is critical.

Program Overview

The vocational rehabilitation program is operated by the Division for Rehabilitation Services (DRS) within DARS. The purpose of the program is to help people with physical, mental or developmental conditions or disabilities prepare for, find and keep employment. According to the DARS website, "gaining skills needed for a career, learning how to prepare for a job interview or getting the accommodations needed to stay employed are just a few of the ways this program helps people with disabilities increase productivity and independence."[172] Services offered in this program are individualized and can include counseling, training, medical services, assistive devices and job placement assistance.[173]

The program partners with businesses to develop new employment opportunities. Program staff also work with public school districts to target individuals with disabilities who need services to help them transition from secondary education to post-graduate school or work.[174] To locate a DRS office an individual can call the inquiry line at 1-800-628-5115. A list of local offices is also available at **www.dars.state.tx.us.**[175]

Eligibility Process

To apply for vocational rehabilitation services, an individual can call, write or visit the DRS office and request an appointment to meet with a counselor. A counselor will be assigned to discuss the eligibility process and requirements, explain the services available, and determine if the individual's disability makes it difficult to work. The goal is to determine how rehabilitation services will enable the individual to become and remain employed. If needed to make the determination, additional information may be requested from doctors, schools and other providers who have information about how the person's disability impacts the ability to work.

Eligibility is based on meeting the following conditions:

- The person has a disability that results in substantial problems in gaining employment.
- Vocational rehabilitation services are required to prepare for, get or keep a job.
- The person is able to get or keep work after receiving services.[176]

Services

Vocational rehabilitation services are based on individual needs and may include:[177]

- Medical, psychological and vocational evaluation to determine the nature and

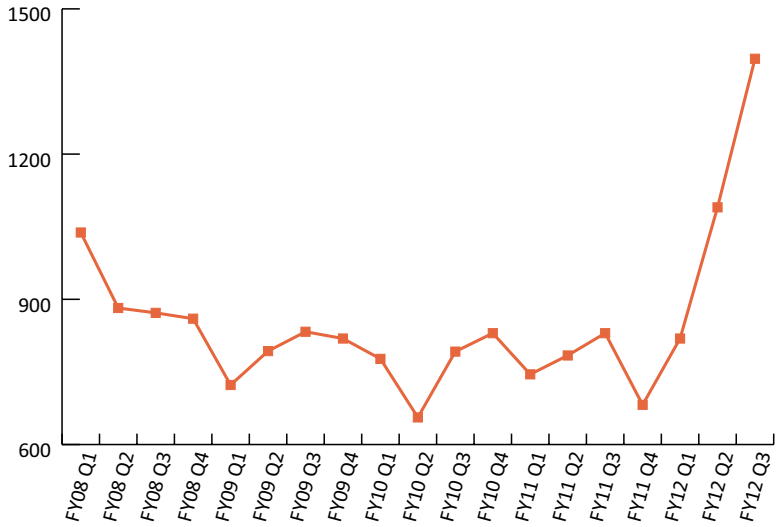
degree of the disability and the consumer's job capabilities.

- Counseling and guidance to help the consumer and family identify and plan for vocational goals and adjust to the working world.
- Training to learn job skills in trade school, college, university, on the job or at home.
- Medical treatment and therapy to lessen or remove the disability.
- Rehabilitation technology devices and services to improve job functioning.
- Training in appropriate work behaviors and other skills to meet employer expectations.
- Job placement assistance to find jobs compatible with the person's physical and mental ability.
- Follow-up after job placement to ensure job success.
- Supported employment.

The supported employment program is intended for people who need extensive assistance to learn skills related to getting and keeping a job but who, after training, can perform satisfactorily without long-term one-on-one support. Continuing services may include consulting with the employer about problem areas, ensuring natural supports such as assistance from co-workers are in place, and providing supportive services such as transportation and self-care management.[178]

Figure 57 tracks the number of individuals assigned to supported employment from FY 2008 through the third quarter of FY 2012.

Figure 57. Number of persons assigned to Supported Employment



Source: Texas Department of State Health Services. (July 9, 2012). *Behavioral health data book, FY 2012, third quarter* [PowerPoint slides]. Retrieved from **www.dshs.state.tx.us/mhsa/databook/**

Vocational rehabilitation services are intended to support people with disabilities in the community as well as support their movement from nursing homes and other institutions to community-based settings.

Utilization and Costs

Figure 58 presents 2011 data on the number of individuals served, average cost per consumer, successful closures and the overall rehabilitation rate.

Figure 58. Utilization and Costs of Vocational Rehabilitation Services

	2011
Number of individuals served	87,902
Average cost per consumer	$2,477
Total successful closures (people getting jobs)	11,496
Rehabilitation rate	58%

Source: Texas Department of Assistive and Rehabilitative Services. (2011). Annual report 2011. Retrieved from www.dars.state.tx.us/reports/annual2011/2011_annual.pdf

Figure 59 details the characteristics of individuals utilizing vocational rehabilitation services in 2011.

Figure 59. Characteristics of Individuals utilizing Vocational Rehabilitation Services

	2011
Total consumers with emotional or mental illness	15,689 (18%)
Total consumers with substance use disorder	2,866 (3%)
Average age at application	36 years
Veterans, honorably discharged	3,742

Source: Texas Department of Assistive and Rehabilitative Services. (2011). Annual report 2011. Retrieved from www.dars.state.tx.us/reports/annual2011/2011_annual.pdf

Independent Living Services

Independent living services offered by DRS are designed to "promote self-sufficiency and enhanced quality of life for people with significant disabilities by focusing on mobility, communications, personal adjustment and self-direction."[179]

Eligibility

In order to be eligible for independent living services, an individual must be certified by a DRS counselor to have a significant disability that results in substantial impediment to the person's ability to function independently in the family or community. There must also be a reasonable expectation that assistance will result in the person's ability to function more independently.

Services

Independent living services may include:

- Counseling and guidance.
- Training and tutorial services.
- Adult basic education.
- Rehabilitation facility training.
- Telecommunications, sensory and other technological aids for people who are hearing-impaired.
- Vehicle modification.
- Assistive devices such as artificial limbs, braces, wheelchairs and hearing aids to stabilize or improve function.
- Other services as needed to achieve independent living objectives, such as transportation, interpreter services and maintenance.

State and Local Criminal Justice Agencies

People living with mental health conditions sometimes become involved with the criminal justice system as a result of conduct that is directly or indirectly related to their condition. Local criminal justice agencies must provide adequate mental health services to local jail detainees. The Texas Department of Criminal Justice (TDCJ) is responsible for providing health and behavioral health services to people who are convicted and sentenced to state jails, state prisons and private correctional facilities.

Policy Concerns:

- Limited capacity to provide quality behavioral health services in the criminal justice system
- Adequacy of inpatient and outpatient competency restoration services
- Impact of incarceration on benefits eligibility

Prevalence of Serious Mental Illness in Criminal Settings

Estimates are that half of all adult inmates in U.S. prisons have at least one mental health condition and that 15% to 24% have a serious mental illness.[180] In FY 2010, Texas jails reported that approximately 20% to 24% of their inmate population had a serious mental illness.[181] A 2010 study by the National Sheriffs' Association found that for every one person with serious mental illness committed to a psychiatric hospital in Texas, nearly eight were in a state prison or jail.[182]

Figure 60 shows the ratio of people with serious mental illness in state prisons or jails to those in a psychiatric hospitals for a number of states and the nation as a whole.

Figure 60. Ratio of People with Serious Mental Illness in a State Jail or Prison to Those Committed to a Psychiatric Hospital, Among Selected States (2010)

State	Ratio of People with Serious Mental Illness in a State Prison/Jail to Those Committed to a Psychiatric Hospital
Nevada	9.8 to 1
Arizona	9.3 to 1
Texas	7.8 to 1
South Carolina	5.1 to 1
Georgia	5.1 to 1
Florida	4.9 to 1
North Dakota	1 to 1
United States (average)	3.2 to 1

Source: Treatment Advocacy Center & National Sheriffs' Association. (May 2010). More mentally ill persons in jails and prisons than hospitals: A survey of the states. Retrieved from www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf

Cost Implications for High Rates of Serious Mental Illness Among Inmates

A study by the Mental Health and Mental Retardation Authority of Harris County and Harris County's Office of Budget and Management examined all releases from jail between January 1, 2004 and January 29, 2008 and found persons with mental illness represented 25% of all offenders but accounted for 37% of the cost of jail stays. The study also found that Harris County's annual costs for an inmate with mental illness was $7,017 per year, compared to $2,599 for other inmates (excluding police and court costs).[183]

People who become involved with the criminal justice system also make up a sizeable portion of the total population receiving public behavioral health services. Between 2007 and 2009, 19% of all adults receiving treatment or services from DSHS were involved in the criminal justice system. They were characterized as having less family and community support, deeper impairment from a mental illness, and housing instability.[184]

Local Criminal Justice Systems and Behavioral Health

Local criminal justice systems consist of local law enforcement agencies, prosecutors, jails, courts and probation departments that are responsible for promoting public safety by enforcing state and local law in a specified region. Local systems are responsible for criminal cases from arrest up to the trial and sentencing stages and beyond, in cases with probation. Local jails hold defendants awaiting trial. Beyond that, some local jails will hold individuals who are convicted of low-level offenses and sentenced for short durations, as well as individuals who are convicted of an offense and waiting for transportation to state facilities.

Programs and services available to defendants with mental health conditions vary from county to county. For example, Dallas County offers an array of diversion-oriented programming including mental health jail diversion coordination, mental health court programs for misdemeanor and felony cases, a dedicated mental health prosecutor, mental health public defenders, and individual case management.[185] In contrast, a mental health court is the only major diversion initiative for defendants with mental health conditions in Tarrant County.[186]

The following programs have been implemented to varying degrees in some, but not all Texas counties.

Jail Diversion Programs

Criminal justice and mental health systems in Texas are collaborating to identify people with mental illness at different points along the continuum of criminal justice involvement and engage them in mental health services. Jail diversion programs offer an alternative to incarceration for people with mental health conditions for whom treatment in a community-based setting is appropriate. There are two general categories of jail diversion programs, as described below. The Substance Abuse and Mental Health Services Administration (SAMHSA) promotes a sequential intercept model of jail diversion with a comprehensive set of opportunities for diversion throughout the criminal justice process.[187]

Pre-Booking Diversion

Pre-booking diversion programs attempt to identify people with mental illness at first contact with law enforcement and, where appropriate, divert them from the criminal justice system before formal charges are brought. These programs tend to rely on effective collaboration of law enforcement personnel and mental health professionals.

Post-Booking Diversion

Post-booking diversion programs seek to divert people with mental illness after they have been arrested through release from pretrial detention or offers of deferred prosecution, on the condition that the person participates in treatment.[188]

Model Jail Diversion Program in Texas

Section 533.108 of the Texas Health and Safety Code permits the prioritization of funds by local mental health authorities (LMHAs) to create a variety of collaborative jail diversion programs with law enforcement, judicial systems and local personnel. San Antonio's jail diversion was implemented in 2003 and is seen as a model for Texas. It employs both pre-booking and post-booking diversion methods.[189] First, mobile crisis outreach teams and law enforcement crisis intervention teams work to identify individuals with mental illness for whom diversion is appropriate (those whose behavior is more a symptom of their illness than an act driven by criminal intent) before they are arrested or booked. Second, the program identifies people with mental illness already in the system and recommends appropriate alternatives to jail, such as community-based treatment or mental health bonds. Finally, it gives priority to providing services when people are released from jail or prison. Between 2003 and 2006, the program diverted more than 4,000 individuals with mental illnesses from incarceration to treatment and saved the county an estimated $5 million annually.[190]

Legislative Changes to Reduce Jail Populations

During the 82nd legislative session attention was given to the length of time people were being held in jails. HB 748 and HB 2725 created a number of significant changes including:

- Allowing courts to rescind an order for competency evaluation at any time if the parties agree that competency is no longer an issue after jail treatment.
- Allowing expert opinion on the likelihood of regaining competency.
- Creating a maximum time limit for forensic commitments.
- Requiring commitment expiration dates on commitment forms.
- Allowing assisted outpatient commitments and judicial authority to order psychotropic medication.
- Prohibiting re-evaluation or re-commitment for a new minor offense within 12 months.
- Prohibiting time served in jail or psychiatric hospitalization from exceeding the maximum sentence for the crime charged.
- Allowing jails to voluntarily provide treatment to individuals prior to a forensic commitment.
- Suspending rather than terminating public benefits during incarceration or forensic hospitalization (suspension is for only 30 days, then benefits are terminated).[191]

Texas Department of Criminal Justice (TDCJ)

TDCJ manages individuals who have been convicted of an offense and sentenced to state jails, state prisons and private correctional facilities. The agency also provides funding and oversight of local probation departments and is responsible for the supervision of offenders released from facilities on parole or mandatory supervision.[192]

Behavioral Health Related Structural Components

Within the TDCJ, there are several offices and agencies that have responsibility for meeting the health and behavioral health needs of inmates. A brief description of each follows.

Health Services Division

The Health Services Division is responsible for ensuring that incarcerated persons have access to quality health care services. The division also investigates grievances and conducts service audits.

Texas Correctional Office for Offenders with Medical and Mental Impairments

Comprised of 21 agencies and organizations, the Texas Correctional Office for Offenders with Medical and Mental Impairments (TCOOMMI) provides a formal structure for criminal justice, health and human services, and other affected agencies to communicate and coordinate on policy, legislative and programmatic issues affecting offenders with special needs.

Office of Mental Health Monitoring and Liaison

The Office of Mental Health Monitoring and Liaison (OMHM&L) monitors mental health services provided to offenders, and provides expert guidance to other TDCJ offices on mental health-related issues.

Correctional Managed Health Care Committee

In 1993, the Texas Legislature created the Correctional Managed Health Care Committee (CMHCC) as the oversight and coordination authority charged with developing a managed health care plan—called an offender health services plan (described below)—for all people confined by TDCJ. The committee manages a partnership arrangement between the department's Health Services Division, the University of Texas Medical Branch at Galveston (UTMB) and Texas Tech University Health Sciences Center (TTUHSC). UTMB is responsible for health care services in facilities in the eastern half of Texas and TTUHSC is responsible for facilities in the western half.[193] Other committee responsibilities are outlined in Section 501, Subchapter E of the Texas Government Code.[194]

Access to Behavioral Health Services in the State Criminal Justice System

Offender Health Services Plan

The offender health services plan, developed by the CMHCC, describes the level, type and variety of health care services made available to offenders incarcerated within TDCJ. The plan contains four classifications of health services for physical, behavioral, dental and substance use care. Classifications of care must be recommended by a qualified mental health provider.

Level I Medically Mandatory Care

Level I medically mandatory care is "essential to life and health and without which rapid deterioration is expected" and for which the recommended treatment intervention is expected to make a significant difference or is very cost effective.[195] Medically mandatory care is authorized and provided to all inmates.

Level II Medically Necessary Care

Level II medically necessary care is "not immediately life threatening but without which the individual could not be maintained without significant risk of serious deterioration or where there is a significant reduction in the possibility of repair later without treatment."[196] Medically necessary care is provided to an extent that it is consistent with evolving standard and practice guidelines.[197]

Level III Medically Acceptable Care

Level III medically acceptable care is for non-fatal conditions where treatment may improve the quality of life but will not in general affect the length of life. Level III conditions are considered on a case-by-case basis by a review process.

Level IV Limited Medical Value Care

Level IV limited medical value care refers to treatments that may be valuable to certain individuals but are significantly less cost effective or produce no long-term gain. This category includes treatment of minor conditions where treatment merely speeds recovery or offers minimal reduction in symptoms or is for the convenience of the individual. Examples of mental health conditions meeting level IV criteria include pedophilia, sleep disorder, and conduct disorder. Treatment of Level IV conditions generally is not authorized; however, a review process may consider exceptional individual cases.

Facility-Based Implementation

Each TDCJ facility must develop a process for individuals who are incarcerated to gain access to medical, mental health, substance use and dental care. Inmates are provided information on how to obtain health care services at intake by the facility to which they are assigned. Facilities may also identify people with mental illness during the intake process or upon referrals from security staff who receive training in identifying mental illnesses.[198]

Behavioral Health Services Descriptions

Mental Health Services

Mental health services available in TDCJ facilities include:[199]

- Emergency mental health services available 24 hours per day, seven days per week.
- Inpatient services, including as necessary diagnostic evaluation, acute care, transitional care and extended care.

- Specialized mental health programs, including programs for offenders experiencing mental illness and exhibiting aggressive behaviors, and offenders with intellectual/developmental disabilities and the chronically self-injurious.
- An administrative segregation step-down program (involves more intensive treatment for offenders with mental illness to ease transition back to the general prison environment).
- Professional services such as medication monitoring and management.
- Crisis management and suicide prevention services.
- Continuity of care services.

Substance Use Services

TDCJ operates a number of programs to serve people with substance use conditions within its Rehabilitation Programs Division, as described in Figure 61.[200]

Figure 61. Substance Use Service Descriptions

Program	Description
Substance Abuse Felony Punishment Facility and In-Prison Therapeutic Community (IPTC)	Six-month in-prison treatment programs, followed by up to three months of residential aftercare, six to nine months of outpatient aftercare and up to one year of support groups and supervision. Judges can sentence individuals to a program in lieu of prison or state jail time, or the Board of Pardons and Parole can require the program as a condition of parole. A nine-month in-prison program provided for people with co-occurring mental health and/or medical diagnoses.
Pre-Release Substance Abuse Program and Pre-Release Therapeutic Community	Intensive six-month programs intended for individuals who are incarcerated with serious substance use conditions, chemical dependency and criminal ideology. Inmates are placed in the program prior to release from confinement on a vote by the Board of Pardons and Parole.
State Jail Substance Abuse Program	Eligible inmates are placed in a 30-, 60- or 90-day track based on an addiction severity index assessment and their criminal history and are provided rehabilitation, counseling and related services designed to meet the needs of the state's diverse incarcerated population.
Driving While Intoxicated In-Prison Program	A six-month program with an aftercare component that uses a variety of education and treatment activities, including group and individual therapy, family education and counseling.

Source: Texas Department of Criminal Justice. (n.d.). Rehabilitation programs division. Retrieved from **www.tdcj.state.tx.us/divisions/rpd/rpd_substance_abuse.html**

Coordination of Behavioral Health Services in the Criminal Justice System

The Texas Correctional Office for Offenders with Medical and Mental Impairments (TCOOMMI) is part of the department's Reentry and Integration Division and provides services to facilitate reentry of people with special needs from incarcerated settings into the community. As described previously, TCOOMMI operates a variety of institutional and community-based programs to coordinate care for older adults and individuals of all ages with special needs, including serious mental illness, intellectual disabilities, terminal or serious medical conditions and physical disabilities.[201]

TCOOMMI's Institutional Services

In FY 2011, 4,762 parolees with serious mental illnesses were referred for continuity of care services. Of this number, 1,725 parolees received TCOOMMI-funded intensive case management and treatment services after release.[202]

Continuity of Care for Individuals with Special Needs

Continuity of care provides pre-release screening and referral to aftercare services for incarcerated people with special needs. Services and supports include:

- Identifying incarcerated people with special needs who require aftercare treatment services.
- Participating in joint treatment planning with the department.
- Providing a positive transition from incarceration to the community.
- Identifying and securing resources in the community for all offenders referred with special needs.
- Working to improve coordination among state criminal justice and other agencies.
- Providing post-release follow-up through monthly reports.

Medically Recommended Intensive Supervision

Medically recommended intensive supervision is an early parole and release program that serves incarcerated people with special needs. The purpose of the program is to release offenders who pose minimal public safety risk as a cost-effective alternative to incarceration.

Medication for Individuals Restored to Competency

Restoration to competency in the criminal justice system occurs when people with mental illness or intellectual disabilities are charged with crimes but found by a court to be incompetent to stand trial. The person must be restored to competency before the legal process can continue. Competency restoration services are usually delivered in state psychiatric hospitals. TCOOMMI reimburses counties for the cost of medication for people returned to a county jail to await trial for up to 76 days after competency restoration discharge from a state psychiatric hospital. If the individual is still incarcerated and awaiting trial after 76 days, the county must decide whether to assume costs for continuing medication or discontinue medication.

TCOOMMI's Community-Based Interventions

Jail Diversion

Jail diversion programs provide alternatives to incarceration for people with mental illness through specialized mental health deputies. These deputies are designated mental health staff who screen for mental health issues; serve as a resource for attorneys or court personnel; advocate for the person with attorneys, court personnel and bond release programs; and provide referral for further medical evaluation or civil commitment.

Service Coordination and Case Management for Adults

Upon release from incarceration, people with mental illness are referred to their LMHAs for services, including case management rehabilitation services, psychological services,

psychiatric services, medication and monitoring, and benefit eligibility services including federal entitlement application processing.

Continuity of Care Adult Programs

Continuity of care programs are designed to conduct pre-release screenings and referrals for aftercare psychiatric treatment services, typically delivered by LMHAs.

Recidivism Rates for Parolees Served by TCOOMMI

The recidivism rate for overall parolee populations was 24% for the most recent three-year period.[203] During the same reporting period, the recidivism rate for parolees that TCOOMMI served was 4.2%. although 13% of adults with serious mental illness who received TCOOMI services were re-incarcerated within three years of release.

Coordination of Care Costs

Cost statistics related to TCOOMMI services are shown in Figure 62.

Figure 62. Costs of Persons Served through TCOOMMI in FY 2011

	FY 2011
Adults served – intensive case management	5,068
Adults served – behavioral health treatment services	6,760
Average cost per person–community services	$1,204
Total costs – TCOOMI adult services (rounded)	$14,241,000

Source: The Texas Department of Criminal Justice. (April 2012). Data Request.

Special Programs for People with Behavioral Health Conditions and Criminal Justice Involvement

Specialty Courts

Specialty courts often are utilized as one piece of a locality's larger jail diversion plan, serving people with serious mental illness and substance use conditions. These courts utilize problem-solving processes to provide community-based alternatives to incarceration and operate under a model that requires the collaboration of judges, prosecutors, public defenders, law enforcement and mental health professionals.

The most common types of specialty courts relevant to criminal law and mental health/substance use are:

- mental health courts.
- drug courts.
- DWI courts.
- re-entry courts.
- veterans courts.

Mental Health Court Models

Mental health courts have been developed across the country as an alternative to the standard adjudication process for people with mental illness. These specialty courts are designed, in part, to reduce the cycling in and out of the justice system that is often the result of untreated mental illness. The Council on State Governments Justice Center and the Bureau of Justice Assistance mental health court primer offers the following working definition.

> A mental health court is a specialized court docket for certain defendants with mental illnesses that substitutes a problem-solving model for traditional criminal court processing. Participants are identified through mental health screening and assessments and voluntarily participate in a judicially supervised treatment plan developed jointly by a team of court staff and mental health professionals. Incentives reward adherence to the treatment plan or other court conditions, nonadherence may be sanctioned and success or graduation is defined according to predetermined criteria.[204]

Harris County recently received a grant from the federal Bureau of Justice Assistance to implement a felony mental health court and began screening applicants for admission to the program in March 2012. People who qualify for the specialty court follow a program lasting at least 12 months and characterized by the following components:[205]

- Comprehensive evaluation to determine the participant's strengths and needs.
- Frequent appearances before the felony mental health court judge.
- Regular visits with specially trained community supervision officers.
- Intensive treatment by mental health professionals.
- Chemical dependency treatment for participants with co-occurring mental health and substance use conditions.
- Random alcohol and drug testing.

More information on mental health courts is available at **www.consensusproject.org/jc_publications/essential-elements-of-a-mental-health-court/mhc-essential-elements.pdf**

Mental Health Public Defender

Criminal cases involving people with mental health conditions often present unique legal issues that require specialized knowledge and skills. Not all Texas counties have a designated public defender, but many of those that do have implemented a division that focuses on defendants with mental health conditions. Other counties without designated public defenders have established Mental Health Public Defenders to better serve defendants with mental health conditions. For example, in 2006 Texas Appleseed, a social justice advocacy organization based in Austin, spearheaded an effort to create a local project where attorneys, social workers, case workers and administrative support staff collaborate to provide holistic representation for people with mental illness who are involved in the criminal justice system. The Texas Task Force on Indigent Defense and Travis County provided grant funding for the project's initiation and they remain the primary funding sources for the mental health public defender services.[206] More information on the Travis County Mental Health Public Defender Office is available at **www.co.travis.tx.us/criminal_justice/mental_health_public_defender/default.asp**

A similar office operates in Fort Bend County.[207] Information on this program is available at **www.co.fort-bend.tx.us/getsitepage.asp?sitepage=32655**

Competency Restoration

People with mental illness facing criminal charges must be found competent to stand trial.[208] If a defendant is found incompetent to stand trial, services to restore competency must be provided so that the person can understand and participate in court proceedings. Competency restoration usually occurs in a state psychiatric hospital at a cost of over $400 per day.[209]

Due to the limited number of state hospital beds, people have stayed in jail for an average of six months waiting for competency restoration services—in some cases longer than they would have been incarcerated if found guilty of the crime for which they were charged.[210] In a lawsuit filed by Disability Rights Texas, a Texas district court recently ruled that people could not be held in jail for more than 21 days in these circumstances. The decision, however is stayed while being appealed.[211]

DSHS has developed outpatient competency restoration (OCR) programs in response to the growing number of forensic commitments to state psychiatric hospitals.

Senate Bill 867 enacted by the 80th Texas Legislature paved the way for four OCR pilots. Seven new sites were added as a result of Rider 78 to Senate Bill 1, 82nd Texas Legislature. The 11 pilot sites are operated by:

- Andrews Center, Tyler
- Austin Travis County Integral Care
- Center for Health Care Services, San Antonio
- Community Healthcore, Longview
- Emergence Health Network, El Paso
- MHMR of Nueces County
- North Texas Behavioral Health Authority, Dallas
- STARCARE Specialty Health Systems, Lubbock
- Spindletop Center, Beaumont
- Tarrant County MHMR, Fort Worth
- Tri-County/Gulf Coast Center, Conroe/Galveston

As of March 2012, over 600 individuals had been provided restoration services through the OCR pilot sites, including 67% with a diagnosis of schizophrenia or bipolar disorder. Many had co-occurring substance use disorders. Approximately 60% of those served had been charged with misdemeanor crimes and 40% with non-violent felonies. The average cost to provide restoration services through OCR was approximately $15,260, far less than the average cost of $33,238 for inpatient restoration in a state hospital.[212] In addition to saving the high cost of hospitalization OCR can reduce costs to jails and local communities by reducing the length of time individuals remain in jail and eliminating the cost of transporting an individual long distances to an available hospital bed.

Additional information on OCR pilots can be found in Section 6. Best Practices and Policy Priorities.

TJJD

State and Local Juvenile Justice Agencies

Texas' juvenile justice system is comprised of the Texas Juvenile Justice Department (TJJD) and local juvenile probation departments throughout the state that work in partnership to provide a continuum of services designed to promote public safety and rehabilitate youth. The juvenile justice system is a civil system, in contrast to the criminal justice system. As a result, different legal terms and concepts are used in juvenile justice procedures. Figure 63 provides a list of important juvenile justice terms and concepts and analogous terms from the adult criminal justice system.

The past two Texas legislative sessions brought significant reforms to this system. During the 2009 legislative session, funding for local juvenile probation departments attempting to reduce commitments to state-level facilities increased, while state-level facilities received significantly less money. In 2011, the 82nd Texas Legislature abolished the Texas Juvenile Probation Commission (TJPC) and the Texas Youth Commission (TYC), the two state agencies that previously managed the state's juvenile justice system. In their place, Senate Bill 653 created TJJD, charged with "increasing the proportion of youths in local custody, rather than committed to state lockups."[213] To this end, TJJD funds and provides oversight to local juvenile probation departments across Texas while continuing some of the functions of the former TYC, including the operation of a limited number of secure facilities for youth.

Policy Concerns:

- Adequate funding for state and local juvenile justice services
- Monitoring of agency reform
- Use of evidence-based practices
- Implementation of trauma-informed care

Preliminary data reveal the financial benefits of relying more on local juvenile probation departments to treat and rehabilitate youth. A 2012 report found that diverting youth from state facilities and programs is cost-effective. While Texans paid $359 per juvenile offender per day for incarceration at TYC in 2010, diversions through in-home programs in Texas cost on average between $48 and $73 a day.[214] Among the 141 counties that elected to receive funds allocated for the diversion of youth from state-level facilities during the 2009 legislative session, commitments dropped by 32% from 2009 to 2010. In contrast, counties that chose not to receive this funding reduced their commitments by only 10%.[215]

This section will describe the behavioral health services available to youth at different levels of involvement with the juvenile justice system. Figure 63 explains some of the terminology related to Texas' juvenile justice system.

Figure 63. Juvenile Justice Terms and Concepts

Juvenile Justice Term/Concept	Analogous Criminal Justice Term/Concept
Delinquent conduct	Criminal conduct
Detention hearing	Arraignment
Pre-adjudication facility	Local jail where individuals are detained prior to trial
Adjudication hearing	Trial
Finding of "true/not true" at adjudication hearing	Finding of "guilt/innocence" at trial
Disposition	Sentence
Committed (also "placed")	Incarcerated
County-run post-adjudication facility	Local or state jail where offender serves short sentences
State secure juvenile correctional facility	Prison

Prevalence of Behavioral Health Conditions Among Youth in the Juvenile Justice System

Youth in the juvenile justice system are more likely than children generally to have mental health and substance use conditions.[216] Nationally, almost 21% of children and youth in the general population have a mental health condition.[217] In comparison, 70% of juveniles in community-based programs, detention centers and secure residential facilities were assessed as having at least one mental health condition, based on a 2006 multi-state study of Texas, Louisiana and Washington.[218] It is unknown if this higher prevalence is due to risk factors such as exposure to trauma, family history, poverty, lack of access to mental health treatment or other factors.[219]

Questions have been raised about the criteria used to identify mental health conditions, the similarities between these criteria and the general characteristics of delinquent youth, and whether this might explain the disproportional representation of youth with mental health conditions in the juvenile justice system. However, even after removing conduct disorders from the analysis, 66.3% of youth in the juvenile justice system met the criteria for a mental health condition.[220] Approximately 27% of youth in the national study had a mental illness serious enough to require immediate treatment.[221]

Behavioral Health Services in the Juvenile Justice System

TJJD, the Texas Correctional Office for Offenders with Medical and Mental Impairments (TCOOMMI) and local juvenile probation departments provide services for youth with mental health and substance use conditions in a variety of juvenile justice settings. The following section describes the services available in each of these settings.

Screening and Assessment

By law, all Texas youth are screened for mental health needs at first contact with local juvenile probation departments using a nationally recognized instrument, the Massachusetts Youth Screening Instrument (MAYSI-2). If a screening indicates that further assessment is appropriate, the department requires local juvenile probation departments to refer youth for further assessment. Eighteen percent of Texas referrals screened in FY 2010 were recommended for further mental health assessment.[222]

In FY 2011, 39% of all juveniles served by local probation departments were identified as having a mental health need, a rate that has steadily risen over the past 10 years.[223] By comparison, this rate was 25% in FY 2001 and 27% in FY 2005.[224]

Youth are included in this estimate if they meet at least one of the following conditions:

- Started a mental health program (excluding counseling) or placement coordinated through local probation departments prior to or within 91 days of starting supervision.
- Were registered as having been served through DSHS prior to or within 91 days of starting supervision.
- Were served through the state's Special Needs Diversionary Program prior to or within 91 days of starting supervision.
- Were identified as having mental health needs by the local probation department.[225]

Behavioral Health Services in State Secure Facilities

Texas has six state secure facilities for youth adjudicated for felony offenses.[226] As of September 2012, there were 1,179 individuals committed to these facilities at an average cost of almost $360 per day.[227] Of all youth committed to state secure facilities in FY 2011, 40% committed nonviolent offenses.[228]

All state secure facilities use a multi-faceted rehabilitation program called CoNextions, which includes life skills training related to mental health and substance use risk and protective factors. Psychiatric and psychological services also are available at all facilities. In FY 2011, 45% of youth in state juvenile facilities were determined to have a serious mental illness, a rate that has remained stable for the past few years.[229]

Specialty Facilities

The Corsicana Residential Treatment Center is a specialty mental health facility located south of Dallas in Navarro County designated solely for committed youth with severe mental health problems. Services offered at Corsicana Residential Treatment Center include evidence-based psychotherapy and behavioral skill-building interventions, chemical dependency treatment, assessment, medication management and other services provided on-site by licensed mental health professionals.[230] Youth who are unable to progress in the program because of the severity of their mental illness can be transferred to a state psychiatric hospital for stabilization or released to community treatment. In 2011, the facility had the capacity to house up to 145 youth, and its daily population usually remained just below capacity at approximately 130 youth.[231]

A recent report by Texas Appleseed, a nonprofit public interest law center, profiled three youth with serious mental illnesses in Texas' secure state facilities. In the case of Corsicana, the study found, "the remote location of the facility makes recruiting and retaining qualified professionals and ensuring the provision of appropriate mental health and other specialized treatment an ongoing challenge."[232] The report is available at: **www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=572&Itemid**

The Ron Jackson State Juvenile Correctional Complex in Brownwood is the only state secure facility that serves girls. Programming and services at this facility are similar to those offered at Corsicana Residential Treatment Center, but modified to reflect the unique individual needs and abilities of the girls.[233]

Behavioral Health Services in County-Level Secure Facilities

Texas has 33 post-adjudication secure facilities operated at the county level. These facilities are for youth adjudicated for misdemeanor offenses and felony offenders not dangerous enough to need placement at a state-level secure facility. Of these 33 county-level post-adjudication facilities, 24 offer programs for youth with mental health conditions and 23 identify themselves as providing programs for youth with substance use conditions.[234]

In addition, there are 50 pre-adjudication facilities operated by counties to detain youth unsafe to release back to the community while awaiting adjudication. Nineteen of these facilities have mental health programs and 15 have substance use programs for detained individuals. More than 600 Texas youth spent over 100 days in secure pre-adjudication facilities at the county level in 2011. Almost half of these individuals were charged with non-felony offenses.[235]

Because local juvenile justice systems rely heavily on county and local funding sources, the type and availability of treatment and support services vary across the state. For a registry of all county-level juvenile justice facilities and the services offered by each, visit: **www.tjjd.texas.gov/publications/other/searchfacilityregistry.aspx.**

Behavioral Health Services for Youth on Parole

TCOOMMI provides continuity of care services to youth released on parole after placement in a secure facility. In FY 2011, 276 discharged youth were linked with community services, including behavioral health treatment, care management and support services.[236] Paroled youth with mental illness also can be placed in therapeutic foster or group living arrangements or residential treatment facilities.

Services are targeted for youth released on parole who have a serious mental illness that requires post-release treatment. Services include:

- Individualized assessments
- Service coordination
- Medication monitoring
- Advocacy services
- Transitional services to other treatment programs
- Benefit eligibility

Community-Based Behavioral Health Services Offered by Local Juvenile Probation Departments

Youth with mental health needs receive services from local juvenile probation departments for a variety of reasons. Some may be diverted from the probation system and provided supervision to include mandated behavioral health services. Youth may also be offered deferred adjudication and provided treatment as a condition of dismissing charges. Youth who are adjudicated and placed on probation may be required to participate in either residential or community-based treatment programs.

Access to treatment is not an entitlement but is based on available resources and providers. Access to services in Texas is widely thought to be insufficient. Among juveniles identified as having a mental illness and served by local juvenile probation departments in FY 2011, only 40% received mental health services.[237]

Figure 64 indicates the number of youth with behavioral health conditions served in the community in FY 2011.

Figure 64. Youth with Behavioral Health Conditions and Juvenile Justice Involvement Served in the Community, FY 2011

Type of Service	Number Served
Mental health services	21,714 (38% of total juveniles served)
Drug treatment programs	3,349
Drug education/prevention programs	5,334

Source: The Texas Juvenile Justice Department. (April 19, 2012). Data Request.

Funding Sources

TJJD grants general revenue funds appropriated by the Texas Legislature to local juvenile probation boards to underwrite a number of probation activities, including special services to juveniles with mental illness and substance use conditions. However, counties provide the majority of funding for community-based juvenile probation services. In FY 2010, counties funded 71% of probation services while state and federal funding accounted for 28% of total funding.[238]

Using a mix of local, state and federal funds, local juvenile probation departments provide a wide array of mental health or substance use services, such as counseling, intensive in-home family services, substance use prevention and intervention, anger management and intensive case management.[239]

State-Funded Behavioral Health Service Programs Available to Local Juvenile Probation Departments

Community-Based Services for Misdemeanor Offenders

Rider 21 during the 80th legislative session appropriated funding to assist local juvenile probation departments in providing community-based services to misdemeanor offenders who, because of statutory changes, were no longer eligible for commitment to state facilities. While new commitments were no longer possible, some youth charged with misdemeanors remained in secure state facilities if they were committed prior to the passage of the legislation. The following fiscal year, TJPC created two grant programs to fund community services: Grant U and Grant X. Grant U is intended for counties with populations over 335,000 and funds services including counseling, education services, parenting classes, life skills, cognitive behavioral therapy, substance use education and mentoring. During FY 2011, a total of $1,193,251 was distributed to Bexar, Cameron, Dallas, Denton, El Paso, Harris, Tarrant and Travis counties under the Grant U intensive community-based pilot program.[240] Of the 839 repeat and serious offenders targeted through this program, 26% had an identified mental health need.[241]

Grant X is open to all local juvenile probation departments and targets individuals who faced possible jail time for misdemeanor or felony charges and were offered deferred adjudication or placed on probation. Of the 1,647 juveniles served through this grant in FY 2011, 27% received a behavioral health referral and 16% received behavioral health services.[242] A total of $5,576,835 was allocated to the Grant X intensive community-based program.[243]

Community-Based Services for Youth Adjudicated for Multiple Serious Felony Offenses

During the 81st legislative session in 2009, Rider 18 in the General Appropriations Act designated community-based services for "serious and chronic felons" as a specially funded program. TJPC established the secure felony placement reimbursement grant fund to provide post-adjudication secure facility resources to local juvenile probation departments for placing youth who have been adjudicated for multiple serious felony offenses.[244] The maximum dollar amount per placement is $22,860.[245] Of the 285 juveniles served in FY 2011, 43% had a mental health need and 22% had a known substance use condition.[246]

Community Corrections Diversion Program

Also in 2009, the 81st Legislature created the community corrections diversion program grant (Grant C) through Rider 21 in the General Appropriations Act. Initially funded with almost $50 million for the biennium, the program provides state funds to local probation departments that decrease their commitments by diverting offenders from state-based incarceration.[247] These funds also are used to support a range of community-based services. Probation departments typically use these funds for counseling, substance use prevention and electronic monitoring. Through the use of this program, counties reduced commitments to state facilities by 32%, and in FY 2010 only 58 of the almost 4,000 youth served through this program were subsequently committed to state correctional facilities.[248] Of the 1,051 youth served in FY 2011, 37% were identified as needing mental health treatment.[249]

Diversion Programs for Youth with Behavioral Health Conditions

Specialty Juvenile Courts

Specialty courts (or problem-solving courts) are designed to address the underlying causes of juvenile justice involvement. They often operate as one piece of a larger continuum of diversion services for youth with behavioral health conditions.

The first juvenile drug courts were created in 1995 in response to new federal funding. By 2008, 467 juvenile drug courts existed nationally.[250] In 2012, Texas jurisdictions reported 12 such courts across the state.[251]

The first juvenile mental health court, modeled on the juvenile drug courts, was created in 2001 in California.[252] In 2007, the National Center on Mental Health and Juvenile Justice identified 18 juvenile mental health courts.[253] By 2012, five Texas jurisdictions reported having a juvenile mental health court, though program descriptions for these courts vary significantly.[254] These courts serve only a small fraction of the youth in their jurisdictions with identified mental health challenges, but a 2010 evaluation found lower recidivism rates for those youth served.[255]

Special Needs Diversionary Program

The 77th Texas Legislature established the Special Needs Diversionary Program to prevent the removal of youth with mental health conditions from their home and reduce further involvement with the juvenile justice system. Specialized probation officers, with a caseload of 15 to 20 youth, work with a mental health professional from the local mental health authority to provide intensive case management and services.[256] Typical services include skills training, individual therapy, medication management, parent education and intensive case management.[257]

A 2012 report found that this program cost $59 per juvenile per day, and the average length of enrollment in the program was 161 days.[258] In FY 2011, the program served 1,410 juveniles in 20 juvenile probation departments. [259] The total amount appropriated for FY 2012 was $1,974,034.[260]

In FY 2010, 73% of enrolled youth completed the program. Referrals to secure state facilities and re-offense rates are measured as indicators of program effectiveness. In FY 2009, only 2% of youth in the program were sent to a secure state facility, the lowest

rate since the program began. The one-year re-offense rate was 42% for all program participants and 36% for those who successfully completed the program.[261]

Other Privately and Federally Funded Diversion Programs

Youth with mental health needs may be diverted from the adjudication process and provided supervision, including mandated treatment in lieu of adjudication. Youth going through an adjudication may be offered the opportunity or be required to participate in treatment as a condition of probation. In either case, youth with mental illness or substance use conditions may receive community-based outpatient services or residential treatment.

Federal and foundation grant funds have underwritten projects that divert youth with mental illness from formal adjudication or incarceration through several local probation departments in Texas.[262]

The Front-End Diversionary Initiative

The Front-End Diversionary Initiative, funded through the McArthur Foundation's Models for Change initiative, links first-time offenders with a mental illness diagnosis to a specialized juvenile probation officer who helps the youth and family access community services. It also includes workforce development and family and youth engagement activities. Texas demonstration sites are in Austin, Dallas, Lubbock, San Antonio and Houston.[263]

Collaborative Opportunities for Positive Experiences

Collaborative Opportunities for Positive Experiences (COPE) is a Travis County juvenile court project funded through the federal Bureau of Justice Assistance. A multi-disciplinary team whose members include a court representative, legal representatives for the youth, the district attorney, probation office, case manager and mental health professionals work with youth with a mental illness who are eligible for deferred adjudication and have committed family involvement. The youth must cooperate with probation supervision and mental health treatment and successfully meet program requirements to get charges dismissed.

Identifying Youth with Brain Injuries

TJJD collaborated with HHSC to secure a grant from the U.S. Department of Health and Human Services to identify youth in the Texas juvenile justice system with undiagnosed brain injuries that contribute to delinquent behavior. In six pilot communities that include Dallas, Fort Worth, Houston, San Antonio, Austin and El Paso, and state youth corrections facilities, youth are screened for brain injuries. When problems are identified, youth are connected to DARS for comprehensive rehabilitation services.[264]

Texas Education Agency and Local School Districts

According to the January 2011 Texas Education Summary, 4,847,844 students were enrolled in 1,237 Texas school districts during the 2009-10 academic year.[265] Approximately 26,300 of these students were receiving special education services with a primary diagnosis of emotional disturbance. Additionally, an estimated one in 10 school-aged children and youth have an undiagnosed or untreated mental health condition[266] that can negatively impact academic performance, classroom behavior and school attendance.[267]

According to the January 2011 Texas Education Summary, 4,847,844 students were enrolled in 1,237 Texas school districts during the 2009-10 academic year. Approximately 26,300 of these students were receiving special education services with a primary diagnosis of emotional disturbance.

Schools have a long history of providing mental health services to students. The President's New Freedom Commission on Mental Health recognized the critical role that schools can play in the continuum of mental health services.[268] Schools can provide convenient access to services for children and families in an environment less stigmatizing than a traditional mental health setting. Though access to various types of mental health services varies by region and school characteristics such as urban/rural location, academic level and student population, most schools offer some level of mental health services.[267]

In recent years, however, counseling and therapy services in schools have become more difficult to provide due to budget reductions and the resulting added responsibilities of school counselors. In many districts, much of the counselors' time is being redirected to non-counseling activities such as test monitoring. A 2009 study found that, "among Texas kids with a diagnosed mental illness, serious emotional disturbance or at risk of being removed from their homes or classrooms for mental health reasons, only 18% receive the mental health treatment they qualify for."[270] Similarly, a 2010 report by the Harris County Mental Health Needs Council found that more than 100,000 juveniles in Harris County have a mental illness and more than 45,000 have a serious mental condition. However, about 70% of the 16,650 who need services from a public health system never get treatment.[271]

School-Based Mental Health Services

A December 2011 Texas A&M University-Kingsville study on access to mental health services found that rural schools struggle to provide mental health services to students. Nearly half of the counselors in the study said less than 25% of their students received adequate counseling services. The study also referenced prior research that said depression, substance use and suicide rates among children are higher in rural areas and that school counselors play a critical role in providing mental health services to students.[272]

Policy Concerns:

- Potential impact of budget reductions on school mental health services
- Disproportionate representation of students receiving special education services in DAEPs and JJAEPs
- Disproportionate representation of minorities in DAEPs and JJAEPs
- Rate of expulsion for students receiving special education services
- Rate of Class C misdemeanor ticketing in public schools
- Bullying
- Lack of accountability of school district law enforcement

The term "school-based mental health services" encompasses a wide variety of programs and models. These different approaches include the services described below.

Among Texas kids with a diagnosed mental illness, serious emotional disturbance or at risk of being removed from their homes or classrooms for mental health reasons, only 18% receive the mental health treatment they qualify for.

School-Financed Services

School-financed services typically include mental health prevention programs and basic treatments such as counseling that are provided on-site by licensed school personnel, such as counselors, psychologists and social workers.

Formal Connections with Community Mental Health Services

Formal connections with community mental health services are agreements made with community mental health agencies to provide services at the school or the community agency.

School District Mental Health Units or Clinics

School districts may operate their own mental health units or health clinics to provide psychosocial and mental health services, staff training and consultation.

Classroom-Based Curricula

Schools may make available prevention-oriented materials provided through teacher instruction and designed to enhance learning through social and emotional growth for all students.

Comprehensive, Multi-Faceted and Integrated Approaches

Districts can bring together multiple activities and community agencies to provide a full range of services to students with mental health needs.[273]

Schoolwide Positive Behavioral Interventions and Supports

Schools are increasingly moving to proactive, coordinated approaches to meet the needs of all students. These initiatives generally include campuswide prevention activities, targeted early intervention for students with risk factors, and individualized services for students with extensive needs. A well-known example of a proactive approach to school-based services is school-wide positive behavioral interventions and supports (SWPBIS). See Figure 65 for an illustration of this model.

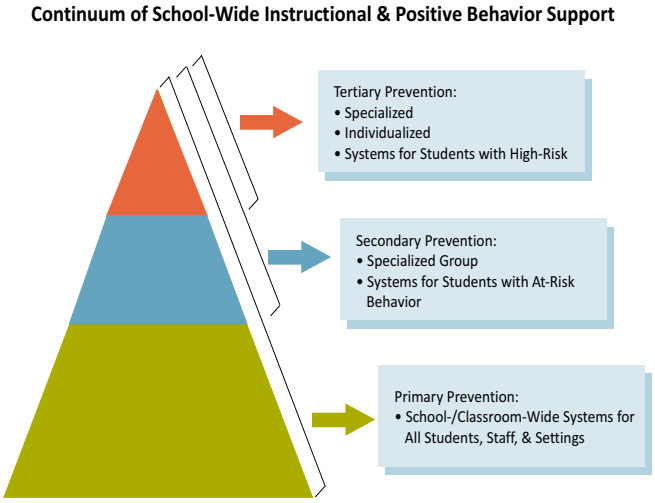
Specific to the promotion of student social, emotional and behavioral health, SWPBIS is an evidence-based practice that uses a three-tiered approach to teach and reinforce appropriate behaviors for all students in place of a punishment-oriented system, changing campus culture to one based on respect and individual responsibility.

- Tier 1, the primary prevention tier, is for 80% to 90% of students. Teachers use a curriculum to teach social skills and expectations that all students and school personnel are expected to follow.
- Tier 2, the secondary prevention level, focuses on the 10% to 15% of students who have risk factors such as exposure to violence or loss of a loved one that cause them to have a higher-than-normal risk of developing mental health conditions. Interventions focus on developing skills and increasing protective factors for

students and their families.

- Tier 3, the tertiary prevention level, focuses on the 1% to 5% of the student population who need an in-depth system of support and includes comprehensive, individualized intervention for students with the most severe or chronic issues.

Figure 65. Continuum of Schoolwide Instructional & Positive Behavior Support



Source: Akron Public Schools. (n.d.) Positive Behavior Supports. Retrieved from **akronschools.dotmarketing.net/departments/ci/school-climate/positive-behavior-supports/**

SWPBIS is an approach that is highly recommended by Texans Care for Children to support students with challenging behavior.[274] Schools that implement the model can achieve favorable outcomes including reduced disciplinary referrals and less use of physical restraints.[275]

Texas Behavior Support Initiative

The Texas Education Agency (TEA) recommends that school districts utilize SWPBIS to address student behavior, but schools are not required to use it or other related approaches.[276] Technical assistance to implement SWPBIS is available through regional educational service centers and the Texas Behavior Support Initiative (TBSI).[277] TBSI was designed to build capacity in Texas schools for the provision of positive behavioral interventions and supports to all students. TBSI training modules assist campus teams in developing and implementing a wide range of behavior strategies and prevention-based interventions.[278] In 2009, more than 800 schools took part in TBSI trainings.[279]

Texas Education Service System for Students with Mental Health Needs

Education Service Centers

Created in 1965, 20 regional educational service centers in Texas provide support and technical assistance to school districts throughout the state in a variety of areas, including special education. This infrastructure supports schools in complying with IDEA. In addition to providing general education support to school districts in their region, service centers may also specialize in a particular area and offer that expertise to schools across the state. The Region IV Education Service Center in Houston specializes in PBIS with the goal of enhancing the education experience for all students, and, through

positive interventions address the needs of students with behavior challenges. For more information on see the Region IV website at **www.esc4.net**.

Additionally, the Region XIII Education Service Center Behavior Team in Austin is comprised specialists in both general education and special education. The team's focus is to provide districts and campuses with technical assistance in the area of behavior management. Region XIII offers behavioral support in the following areas:

- Behavior support services cooperative
- Positive behavior interventions and supports initiative
- Referral assessment management portal
- Resources
- Satori alternative to managing aggression
- Safety audit
- Texas Behavior Support Initiative
- Workshops

For additional information, see the Region XIII website at **www4.esc13.net/behavior/**.

While more than 26,000 Texas students receive special education services for emotional disturbance, many more students (both those receiving special education services and those who don't) receive some level of mental health support, primarily through limited counseling sessions. School nurses and licensed school psychologists are primary providers of mental health services to students in the state.[280] State level data are not available on the total number of students provided mental health services by school districts in Texas, or the associated costs.

Coordinated School Health Model

Counseling and mental health services are a core element of TEA's Coordinated School Health Model.[281] The Department of State Health Services (DSHS) defines coordinated school health as "an integrated, systematic set of planned, sequential, school-affiliated strategies, activities and services designed to advance student academic performance and promote their optimal physical, emotional, social and educational development. It is coordinated by a multidisciplinary team that is accountable to the community for program quality and effectiveness."[282]

A 2005 TEA study found that counselors spent less than 33% of their time at the elementary level and 12% at the high school level providing counseling.

Source: Texas Education Agency (2005). Assessment of Existing School-Based Mental Health and Substance Use Programs.

The 8-Component Model for Coordinated School Health consists of eight health-related areas covering all aspects of the school environment that are linked together to function and coordinate as a unified, effective system to the benefit of the entire school community. However, Texas school counselors report that they often do not have time to provide counseling to students because of other assigned duties, primarily test monitoring and coordination.[283]

Communities in Schools

A joint state and local dropout prevention program, Communities in Schools, provides case management and counseling among other activities for students in 148 of the 1,237 school districts in the state.[284] Some school districts also allow community mental health agencies to provide services on campus.

Special Education Services

The Individuals with Disabilities Education Act (IDEA), first passed in 1975 (as the Education for All Handicapped Children Act PL 94-142) and reauthorized in 2004. Schools are accountable for the academic performance of all students, including those with emotional disturbance or mental health conditions. If a child's academic progress is impacted by a mental health condition, the IDEA requires schools to provide special education and related services based on an individualized educational plan, which may include mental health treatment and supports. Schools are not required to provide special educational or mental health services if a child's mental health condition does not impact academic progress.[285]

Eligibility for Special Education

Texas schools are required by federal law to provide special education for students whose emotional disturbance interferes with their ability to learn. Eligibility is based on the student exhibiting one or more of the following characteristics to a marked degree over an extended period of time in ways that adversely affect the student's educational performance:

- An inability to learn that cannot be explained by intellectual, sensory or health impairments.
- An inability to relate appropriately to peers and teachers.
- Inappropriate types of behaviors or feelings under normal circumstances.
- A general mood of unhappiness and depression.
- A tendency to develop physical symptoms, pains or fears associated with personal or social problems.

In determining whether special education services will be provided, school personnel also seek evidence that the student's behavior and need for services is not the result of a temporary reaction to home, school or community situations.

Process for Determining Special Education Needs and Services

Special education and related services can include a wide range of supports depending on the student's needs, including assessment, counseling, case management, skills training, specialized classes and residential treatment for educational reasons. The types of special education and supports needed are determined through an annual admission, review and dismissal (ARD) meeting with the student, parents or caregivers and school personnel. An individualized education plan is developed to specify the behavioral supports and interventions to be provided by the school district for the student.[286]

To assure that students in special education successfully transition from school to appropriate post-school activities such as postsecondary or vocational education, integrated employment and independent living, schools must begin individual transition planning with students and their families by age 14.[287] Schools are required to identify needed courses and related services and to develop adult living objectives through the individualized education plan. The availability, comprehensiveness and quality of transition services available in Texas vary widely across the state.

A recent Texas study, *Breaking School Rules: A Statewide Study of How School Discipline Relates to Student Success and Juvenile Justice Involvement*, found that three-fourths of

students who qualified for special education had been suspended or expelled at least once. Students in special education because of emotional disturbance were even more likely to be suspended or expelled.[288] Referral to a disciplinary or juvenile justice alternative education program may depend more on where the student goes to school than on the student's behavior.

Special Education Utilization

Nationally, the proportion of students identified as having serious emotional disturbance and therefore qualifying for special education services fell from 2001 to 2010, from 1.0% of all students to 0.8% of all students.[289] A 2012 report found that on average, 13% of students are in special education across all states, and two-thirds of states are above that rate.[290] With 9% of its student population identified as needing special education services, Texas has the lowest percentage of students in special education.[291]

Disciplinary Alternative Education Programs

Under state law, schools have the option to remove or expel students, even those in special education, to disciplinary alternative education programs (DAEPs) or juvenile justice alternative education programs (JJAEPs). Every Texas school district is required to provide a DAEP, and districts may join together to support one such program. In smaller, rural districts, a DAEP may be a separate classroom on the school campus, but more frequently DAEPs are housed at separate campuses.[292] Additionally, a DAEP that serves a student with a disability in special education must provide services as set out in the student's individualized education plan.[293]

A student's removal to a DAEP is *mandated* for the following infractions:

1. Committing a felony or engaging in conduct punishable as a felony.
2. Injuring another person during an assault.
3. Selling, giving, possessing or being under the influence of a dangerous drug or alcohol.
4. Committing an offense that involves volatile chemicals, public lewdness or retaliation against a school employee.[294]

Texas schools also have "wide discretion" to send students to a DAEP for other offenses listed in their student code of conduct. Depending on the school district, these offenses "can range from fighting and gang activity to disrupting class, using profanity, playing a prank such as throwing a tennis ball in the hallway and narrowly missing another student, misusing a school parking decal, inadvertently bringing a prescription or over-the-counter drug to school, or doodling in class when the drawing contains a weapon."[295] According to Texas Appleseed, many school districts have exercised the latitude under the Texas Education Code to enforce their own student codes of conduct and, as a result, the vast majority of students sent to DAEPs in Texas are there at the discretion of the school district.[296] Referral to a disciplinary or juvenile justice alternative education program may depend more on where the student goes to school than on the student's behavior.[297] Additionally, the *Breaking School Rules* study found, "because there has been little monitoring and oversight of DAEPs, the quality of the programming and instruction varies among districts, with some students in DAEPs poorly served by under-resourced programs."[298]

Because use of referrals for minor behavior infractions can have significant impact on individual students and the entire campus environment, the high level of discretionary referrals has been brought to the attention of the legislature and will continue to be monitored and discussed by policymakers. In addition, in 2011, the Legislative Budget Board expressed the following concerns about DAEPs:

- Failure to staff the DAEP with certified teachers.
- Failure to provide a learning environment equivalent to mainstream campuses.
- Inadequate training for DAEP instructors and staff.
- Lack of instructional alignment between DAEP and mainstream campuses.
- Insufficient communication between a student's home campus and DAEP.
- Absence of transitional programming upon a student's return from a DAEP.[299]

Juvenile Justice Alternative Education Programs

In 1995, the Texas Legislature required the development of juvenile justice alternative education programs (JJAEPs) to provide ongoing educational services for students who have been expelled. Every county with a population of more than 125,000 residents must have such a program. Legislative intent in creating JJAEPs was "to provide continuing educational opportunities for students expelled from school for the most serious offenses."[300] School districts without a JJAEP may send expelled students to DAEPs or opt to send them "to the street" by having them serve the length of their expulsion unsupervised and outside a school setting.

Students can be expelled from Texas public schools for a range of offenses, "from serious criminal behavior at or within 300 feet of a school, to more minor student code of conduct violations committed while in the school district's DAEP."[301] Discretionary expulsions, however, outnumber mandatory expulsions, and discretionary expulsions from a DAEP for "serious or persistent misbehavior" represent the largest percentage of discretionary expulsions. The majority of expelled students are sent to JJAEP. Texas Appleseed found that "placing students in JJAEPs for 'serious or persistent misbehavior' not only fails to correct behavioral problems, but leads to increased risk for future involvement in the juvenile justice system."[302]

School Ticketing – Class C Misdemeanor

School districts are authorized under state law to have their own police departments. These district police use Class C misdemeanor ticketing to deter unwanted behaviors in schools. Texas Appleseed's analysis of school discipline practices show an increase in the use of "Class C misdemeanor ticketing to address low-level student misbehavior."[303] This use increased as the number of school district police increased. According to the Texas Appleseed analysis, ticketing takes place for minor behavior infractions that don't warrant referral to DAEPs.[304] Students are being ticketed for infractions such as getting in fights, offensive language, disorderly conduct and classroom disruption – things that used to be handled by school administrators. A Class C misdemeanor charge can have serious consequences for the student and parents including high court costs and increased stigma.

In April 2010, a Senate Criminal Justice Committee hearing focused on school disciplinary practices including the high use of ticketing. According to a *Texas Tribune* article, during the hearing committee members reflected on the concern that the use of ticketing was

not effective. Others expressed concern that the justice system was becoming a substitute for school discipline.[305] As long as ticketing of students, some as young as six years old, remains high, school ticketing will remain a priority policy issue.

School Expulsion and Suspension Statistics in Texas

In the 2005-06 school year, Texas school districts sent about 100,000 students to DAEPs.[306] The size of the school district, though, does not correlate with the number of discretionary student expulsions. Of the more than 1,000 school districts in Texas, about half did not expel any students in 2007-08. This suggests a wide variation in school districts' policies governing discretionary expulsion of students.[307]

The most recent national data shows that while Texas educates about 9% of all school-aged children in the U.S., the state is responsible for approximately 12% of the students expelled from the nation's public schools.[308] Special education students make up only 10% of the student population in Texas but account for 21% of all expulsions.[309] Compared to the whole student population, African American special education students are three times more likely to be expelled and Hispanic students are more than 2.5 times as likely to be expelled.[310]

While total expulsions, whether to a JJAEP or to the street, increased approximately 38% during the five-year period between 2002 and 2007, there was a 26% decrease in expulsions from Texas schools between 2007 and 2009. From a high of 11,135 total expulsions in 2006-07, expulsions dropped to 8,202 in 2008-09. In that period, 5,103 Texas students were expelled to a JJAEP and 3,099 were expelled "to the street."[3111]

The report *Texas' School-to-Prison Pipeline: School Expulsion*, provides greater detail on Texan expulsions, and is available at **www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=380&Itemid=** Additionally, a new report released in October 2012 providing an analysis of cost effective alternatives to exclusionary discipline practices (expulsions, suspensions, DAEP/JJAEP costs, etc.) can be found at **www.texasappleseed.net/index.php?option=com_docman&task=doc_download&gid=848&Itemid**.

Texas Department of Housing and Community Affairs

The Texas Department of Housing and Community Affairs (TDHCA) performs many functions related to the development and operation of several major affordable housing programs. TDHCA acts as a conduit for federal grants for housing and community services and as a finance agency for state and other housing funds. TDHCA also ensures compliance with federal and state laws governing various housing programs. It serves as a financial and administrative resource, providing essential services and affordable housing opportunities to low-income residents of Texas.

Policy Concerns:

- Lack of affordable housing
- Coordination of affordable housing and services through a 1915(i) waiver
- Section 8 housing waiting list
- Development of permanent supportive housing options

Although there is significant overlap in the population served by TDHCA's affordable housing programs and many of the programs operated by Texas' health and human service agencies, many of the concepts that are essential to the understanding of affordable housing are not used in health and human service programs, and vice versa. TDHCA recently published the State Agency Reference Guide and Training Manual to help cross-educate housing and health services staff. The guide is available at **www.tdhca.state.tx.us/hhscc/reference-guide.htm.**

Figure 66 provides a brief explanation of some of the most important affordable housing terms and concepts.

Figure 66. Affordable Housing Terms and Concepts

Public Housing Authority (PHA)	PHAs are governmental entities that are responsible for the operation of subsidized housing and rental assistance programs. Contact information for the PHAs throughout Texas can be found at **www.hud.gov/offices/pih/pha/contacts/states/tx.cfm.** The U.S. Department of Housing and Urban Development (HUD) provides funding for affordable housing through certain federal programs directly to PHAs in participating jurisdictions. A list of all participating jurisdictions in Texas can be found at **www.tdhca.state.tx.us/home-division/docs/HUD_PJs_Full_List.pdf.** TDHCA is itself a PHA and receives and distributes HUD funds for nonparticipating jurisdictions throughout Texas.
Area Median Family Income (AMFI)	HUD uses the most recent census data on median family income and results from the Census American Community Survey to determine median family income in communities throughout the country, or AMFI. Note: Low-income households are those whose income does not exceed 80% of AMFI. HUD breaks "low-income" down even further as follows: ○ Low –income = 80% and below ○ Very low-income = 50% and below ○ Extremely low-income = 30% and below Some HUD and TDHCA programs require that funds be used for units that will serve households at a certain percentage of AMFI.
Development Assistance	Affordable housing funds often come with use restrictions. Development assistance funds can be used for the acquisition of property, construction of property, and rehabilitation of existing property.

Rental Assistance	Rental assistance funds help tenants with low incomes afford rent at or near market rate for specified housing units. Typically, rental assistance funds allow eligible tenants to pay about 30% of their income toward rent. A subsidy pays the difference between that amount and the market rent for the specific unit. Rental assistance comes in two basic forms: **Tenant-based rental assistance** applies to rental assistance programs in which the entity providing the subsidy has a contract with the tenant. This allows the tenant to seek housing from more providers in more locations. **Project-based rental assistance** applies to rental assistance programs in which the entity providing the subsidy has a contract with the housing provider. Tenants then lease the unit to which the subsidy applies from the provider.
Services Assistance	Some affordable housing funds come with use restrictions relating to the financing and coordination of health and human services for tenants with low-incomes. Programs that provide service funds are often specifically designed to serve people with disabilities.

Affordable Housing

There is a severe lack of affordable housing in Texas. Affordable housing is defined by the State Affordable Housing Corporation as housing where the occupant is paying no more than 30% of gross income for gross housing costs, including utility costs.[312] TDHCA estimates that the state meets less than 1% of its total affordable housing need.[313] This has dire consequences for many Texans living with behavioral health conditions. In 2010, the average monthly rent for a one-bedroom apartment in Texas was just under $670.[314] Individuals who were eligible for supplemental security income (SSI), including many people who are unable to work due to serious mental illness, would have had to pay 99% of their $674 monthly income toward housing.[315] Without affordable housing options, people with serious mental illness are priced out of the housing market. A recent Travis County study found that 69% of people with four or more psychiatric hospitalizations within a certain period were homeless.[316] Safe, stable and affordable housing is an essential component of support systems that facilitate recovery from mental illness.

The overwhelming negative stigma associated with mental illness also prevents many Texans from participating in community life and accessing affordable housing. Recent surveys indicate that only 45% of participants feel comfortable interacting with an individual with a diagnosis of bipolar disorder or schizophrenia.[317] More than 70% of participants said they would be afraid for their safety around a person with schizophrenia who has not received treatment.[318] The incidence of violence among people with serious mental illness who do not use substances is no greater than that of the general population.[319] In fact, people with serious mental illness are more likely to be the victims of violent activity.[320] Still, inaccurate public perception perpetuates the unwarranted assumption that people with mental illness are unworthy or incapable of living meaningful, productive lives in their community.

The incidence of violence among people with serious mental illness who do not use substances is no greater than that of the general population. In fact, people with serious mental illness are more likely to be the victims of violent activity.

Permanent Supportive Housing

Permanent supportive housing is a cost-effective, evidence-based practice that combines stable and affordable living arrangements with access to flexible health and human

services designed to promote recovery for people with behavioral health conditions. The core elements of permanent supportive housing are:

- A high degree of choice offered to tenants.
- Functional separation of housing management and services staff.
- Affordability.
- Integration with the surrounding community.
- Full rights of tenancy under federal and state law.
- Immediacy of access to housing.
- Available services and supports.[321]

No permanent supportive housing project is assumed to be able to offer all of these core elements, but the extent to which they are able to do so tends to predict whether the project will be successful. For example, a particular permanent supportive housing site may require the prospective tenant to demonstrate readiness to live independently before leasing an apartment. This denies the prospective tenant immediate access to housing, but does not necessarily mean the project will be unsuccessful in promoting independence and facilitating recovery. For more information on permanent supportive housing see the SAMHSA resources at **store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510.**

Senate Bill 1878, 81st Texas Legislature created the Housing and Health Services Coordination Council (HHSCC), charged with increasing state efforts to offer service-enriched housing through increased coordination of housing and health services. Service-enriched housing is "integrated, affordable and accessible housing that provides residents with the opportunity to receive on-site or off-site health-related and other services and supports that foster independence in living and decision-making for individuals with disabilities and persons who are elderly."[322] The executive director of TDHCA chairs the council. The remaining members are either governor appointees or state agency representatives. The council's biennial plan with housing and service recommendations can be found at **www.tdhca.state.tx.us/hhscc/docs/12-13-BiennialPlan.pdf.**

In collaboration with TDHCA, the Department of State Health Services (DSHS) is working to increase the availability of permanent supportive housing for people with serious mental illness. DSHS has included an exceptional item request in their FY 2014 - 2015 legislative appropriations request for state match funds for a 1915(i) waiver to the Texas Medicaid state plan to support the development of permanent supportive housing opportunities. This will allow Texas to draw down significant federal matching funds.

Housing and Service Programs for People with Behavioral Health Conditions

TDHCA operates several affordable housing programs. Some programs are specifically designed or have components that are specifically designed to serve people with disabilities. The following programs provide some of the most significant housing and community service resources for people with mental illness currently operated by TDHCA. In addition to these programs, local housing and urban development (HUD) programs across the state offer additional opportunities for housing when funds are available.

Homeless Housing and Services Program

The Homeless Housing and Services Program (HHSP) was established by Rider 18 to Senate Bill 1, 81st Texas Legislature and was later codified. Through this program, the state provides funding to the eight largest cities in Texas – Arlington, Austin, Corpus Christi, Dallas, El Paso, Fort Worth, Houston and San Antonio – to provide services to individuals and families experiencing homelessness. Services include case management, housing placement and supports designed to help people retain housing.

HHSP received an initial appropriation of $20 million during the 81st legislative session but did not receive a direct appropriation during the 82nd legislative session. TDHCA identified $5 million for the program for FY 2012. For more information, visit **www.tdhca.state.tx.us/community-affairs/hhsp/index.htm.**

HOME Tenant-Based Rental Assistance

TDHCA operates as a conduit for the U.S. Department of Housing and Urban Development's HOME Investment Partnership program. Five percent of the federal funds received by TDHCA through this program are reserved for people with disabilities throughout Texas. With these funds, TDHCA operates a temporary tenant-based rental assistance (TBRA) program that assists tenants with the cost of moving and provides rental subsidies to tenants seeking affordable housing in their community. HOME rental subsidies last up to 24 months and are contingent on participation in a self-sufficiency program.

Project Access

Project Access is part of TDHCA's Section 8 Housing Choice Voucher program, which provides rental assistance payments to individuals and families whose annual gross income does not exceed 50% of AMFI. To be eligible for a Project Access voucher, an individual must "have a permanent disability as defined in Section 223 of the Social Security Code or be determined to have a physical, mental or emotional disability that is expected to be of long-continued and indefinite duration and impedes one's ability to live independently, and:

- (A) Be an at-risk applicant and a previous resident of a nursing facility, intermediate care facility, state psychiatric hospital, or board and care facility as defined by the U.S. Department of Housing and Urban Development, or
- (B) Be a current resident of a nursing facility, intermediate care facility, state psychiatric hospital or board and care facility at the time of voucher issuance as defined by HUD, and
- Be eligible for the DSHS pilot program for residents of Texas state psychiatric hospitals at the time of voucher issuance."[323]

Up to 10% of Project Access vouchers are reserved for a pilot program operated by DSHS and TDHCA designed to assist current and former residents of Texas state psychiatric hospitals obtain stable housing with access to vital services and supports in their community. Additional access to these vouchers is being requested through a rule change by TDHCA staff that must be approved by the TDHCA board. For more information, visit **www.tdhca.state.tx.us/section-8/project-access/index.htm.**

Section 811 Supportive Housing for People with Disabilities

Section 811 is one of HUD's supportive housing programs for people with disabilities and is authorized by the Cranston-Gonzales National Affordable Housing Act of 1990. The recently reformed program provides interest-free development funds in the form of operating subsidies to nonprofit developers of affordable housing for people with disabilities and provides direct rental assistance to state housing agencies.

On July 31, 2012, TDHCA submitted an application to HUD for a Section 811 Project Rental Assistance Demonstration Program. If awarded, this program will provide up to $12 million in project-based rental assistance (PBRA) funds over a period of five years. TDHCA has indicated that people with serious mental illness are a target population for this program, along with transition-age youth and people with disabilities exiting institutions through STAR+PLUS, Community-Based Alternatives and Home and Community-Based Services waiver programs.

The above listed programs are not a comprehensive list of all the affordable housing resources in Texas. There are a number of other federal and state programs operated by TDHCA and other public housing authorities throughout Texas. Though many of these programs are not specifically designed to assist people with behavioral health conditions or even people with any type of disability, they serve as resources for increasing the affordable housing stock in Texas. Find out more about the programs operated by TDHCA at **www.tdhca.state.tx.us/overview.htm.** A list of all federal affordable housing programs can be found at **www.hud.gov/funds/.**

Housing Trust Fund

While the above programs provide invaluable resources for housing developers, providers and the individuals who ultimately utilize affordable housing, they fall far short of addressing the overall need in Texas. The Housing Trust Fund (HTF) is the only state funding source dedicated to the acquisition, development and operation of affordable housing. Created during the 73rd Texas legislative session in 1993, HTF use is limited to assisting individuals and families of low and very low incomes, providing technical assistance and capacity building to nonprofit organizations engaged in developing affordable housing, and serving as security for repayment of revenue bonds issued to finance housing for individuals and families of low and very low income.[324]

HTF provided just $5.85 million for affordable housing in each year of the current biennium, less than 10% of all affordable housing funds available to TDHCA.[325] This represents a decrease of $5.1 million from the previous biennium.[326]

Impediments to Fair Housing Choice

In 1968, Congress enacted Title VIII of the Civil Rights Act, commonly referred to as the Fair Housing Act, which prohibits discrimination in the sale or rental of units in the private housing market on the basis of race, color, religion, sex, national origin, familial status and disability, including mental illness.[248] As part of that law, recipients of HUD funds are under an obligation to affirmatively further nondiscrimination policies, not just prohibit discrimination. In an effort to comply with this obligation, Texas is currently conducting an analysis of impediments to fair housing choice throughout the state.

Phase one of the most recent analysis of impediments focused on the communities impacted by Hurricane Ike, which struck Texas in September 2008. The phase one report can be found at **www.tdhca.state.tx.us/program-services/fair-housing/analysis-impediments-2010-1.htm.**

Phase two is ongoing and will focus on communities throughout Texas. More information about phase two can be found at **www.tdhca.state.tx.us/program-services/fair-housing/analysis-impediments-2010-2.htm.**

Boarding Homes

Due to the severe shortage of affordable housing throughout Texas, many people with behavioral health conditions reside in boarding homes. During the 81st legislative session, the Texas Legislature directed HHSC to develop and publish model standards for the operation of boarding home facilities. Those model standards define boarding homes as facilities that:

- Furnish, in one or more buildings, lodging to three or more persons with disabilities or elderly persons who are unrelated to the owner of the establishment by blood or marriage.
- Provide community meals, light housework, meal preparation, transportation, grocery shopping, money management, laundry services, or assistance with self-administration of medication but do not provide personal care services to those persons.

The legislation, however, did not require cities to implement the model standards. Consequently many problems with this type of housing continue to exist. The full boarding home model standards are available at **www.hhsc.state.tx.us/BoardingHouseModelStandards.pdf.**

Texas Veterans Commission

Texas is home to nearly 1.7 million veterans of the armed forces, more than any other state except California.[328] Veterans face a myriad of challenges as they transition from active duty to civilian life. Among these challenges is an increased risk for behavioral health conditions. Approximately one in every five veterans of the wars in Iraq and Afghanistan has major depression or post-traumatic stress disorder (PTSD). About three in every four Vietnam combat veterans with PTSD have a co-occurring substance use condition.[329] Veterans with behavioral health conditions experience more serious psychiatric symptoms and worse general health. The U.S. Department of Veterans Affairs (VA) estimates that veterans account for one out of every five suicides in the U.S.[330] Unfortunately only about half of veterans with behavioral health conditions access services.[331]

Though veterans are less likely than the general population to be uninsured, 1.3 million veterans nationwide lack access to behavioral health services. Texas is home to 186,000 uninsured veterans and family members, the most of any state.[332]

The Texas Veterans Commission (TVC) represents Texas before the VA and acts as an advocate for Texas veterans attempting to secure earned benefits. TVC focuses on the following program areas: veterans employment services, veterans education services, claims representation and counseling, and funding assistance. Both the claims representation and counseling and funding assistance programs impact veterans' ability to access behavioral health services.[333]

The U.S. Department of Defense Military Health System is responsible for providing health care to active duty and retired U.S. military personnel and their families. For more information, visit **www.health.mil.**

Policy Concerns:

- Access to appropriate mental health and substance use services for veterans
- Adequate funding for behavioral health services for veterans
- Coordination of services between federal and state systems
- Adequate housing supports for veterans with mental health conditions

Claims Representation and Counseling

TVC's claims representation and counseling program helps veterans and their family members apply for disability benefits and enroll in VA health care programs. Veterans health care services are administered on a regional level by a system of 21 veterans integrated service networks (VISN), each containing a hierarchy of medical centers, on-site outpatient clinics, community-based outpatient clinics and vet centers. Texas is divided into three VISNs with multiple clinics and vet centers throughout the state. For a map of VISNs and information about local resources, visit **www2.va.gov/directory/guide/map.asp?dnum=1.** TVC claims related to entitlements secured through service in the armed forces increased by 19% in FY 2010 and again by 18% in FY 2011.[334] Claims representation and counseling is projected to account for over $4.5 million of TVC's $29.2 operating budget for FY 2012.[335] Counselors handled 179,981 benefit cases on behalf of veterans and family members, yielding more than $2 billion in compensation and pension benefits in FY 2011.[336] Texas leads all other large states in monetary recovery of veterans compensation and pension benefits.[337]

TVC employs counselors accredited by the VA to provide direct representation in claims and appeals as well as general assistance with the process of securing benefits at many

VISN facilities. Claims counselors act as a liaison between the veteran and VA medical facilities and assist veterans with applications for VA compensation benefits.[338]

The following sections describe VA benefits eligibility and available VA behavioral health services that can be accessed with the assistance of TVC counselors.

Eligibility for VA Benefits

Eligibility for most VA benefits, including health services, is based upon discharge from active military service under other than dishonorable conditions.[339] Veterans are assigned to one of eight priority groups upon enrollment. The highest priority groups include veterans with service-connected disability ratings, veterans who are former prisoners of war, veterans awarded the Purple Heart Medal, veterans awarded the Medal of Honor, veterans discharged with a disability incurred or aggravated in the line of duty, and veterans awarded special eligibility due to a disability incurred during treatment or vocational rehabilitation.[340]

VA Behavioral Health Services

Both inpatient and outpatient behavioral health services are available in a wide array of VA settings, including primary care clinics, general and specialty outpatient mental health clinics, residential care facilities and community living centers. Services and programs include specialized PTSD services, psychosocial rehabilitation and recovery services, suicide prevention programs, evidence-based psychotherapy programs and substance use services. The VA also provides behavioral health services for family members and survivors of active duty military personnel and veterans.[341] For a comprehensive description of federal benefits available to veterans, family members and survivors, visit **www.va.gov/opa/publications/benefits_book.asp.**

The VA recently announced that it is hiring 1,600 new mental health professionals and 300 support staff in response to an executive order calling for improvements in mental health services for veterans, current service members and military families.[342]

Fund for Veterans' Assistance

The Fund for Veterans' Assistance (FVA) is a combination of state funds and private donations used to award two categories of grants to eligible organizations that provide direct services to veterans and their families. First, FVA general assistance grants reimburse charitable organizations, local government agencies, and veterans service organizations (VSO) for providing direct support services to veterans and their families, including housing assistance, counseling for PTSD and traumatic brain injury, transportation to medical appointments, and information and referrals to other services.[343] Second, Housing4TexasHeroes grants support nonprofit or local government organizations that provide temporary and permanent housing assistance for veterans and their families.[344]

Since the inception of the program in 2009, the FVA has provided $21.5 million to over 80 grantee organizations statewide.[345] As of April 2012, 22% of the grants funded counseling services.[346] During FY 2011, FVA grantees assisted approximately 65,700 veterans and their families.[347] For a list of current and past FVA grantees, visit **www.tvc.state.tx.us/Grant-Award-History.aspx.**

Section 5. Medicare and Private Insurance

Medicare and private commercial insurance offer behavioral health benefits to many Texans. While the state's role in both is limited (neither operate with state funding), state policy can impact access and availability of mental health services.

Medicare and Mental Health

Medicare is a federal health care program that provides inpatient and outpatient care for individuals age 65 or older. Medicare also covers people under age 65 with certain disabilities, and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).[348] The program also provides prescription drugs for individuals who enroll. The program is funded and administered by the federal government and is divided into four coverage areas (parts A, B, C and D), described below. In 2009, 2,403,826 Texans were eligible because of their age, while 474,392 were eligible because of a disability.[349] Figure 67 details the number of Texans enrolled in Medicare.

Figure 67. Texas Medicare Enrollment

	2010	2011	2012
Total	2,852,000	3,044,936	3,187,332

Source: Kaiser Family Foundation. (2012). Texas: Medicare enrollment. Retrieved from www.statehealthfacts.org/profileind.jsp?cat=6&sub=74&rgn=45

While Medicare covers a broad array of mental health services, special rules limit the scope of coverage and reimbursement. Medicare coverage of mental health benefits is not as extensive as coverage for other services.[350] Though some benefits are coordinated with Medicaid, a state-run program, the Medicare program is funded and administered by the federal government.

Medicare Part A

Medicare Part A provides inpatient hospital insurance and covers inpatient mental health care if provided in a general or psychiatric hospital. The care includes room, meals, nursing and other related services and supplies. For services as an inpatient in a psychiatric hospital, Part A pays for up to 190 days during a lifetime. Most Americans over age 65 automatically qualify for Part A based on their work history and payroll deductions for the program. People who do not qualify can pay to enroll.

Medicare Part B

Medicare Part B covers outpatient diagnostic and treatment services provided by physicians, including psychiatrists, as well as clinical psychologists, social workers, psychiatric nurse specialists, nurse practitioners and physician assistants. Medicare reimburses these clinicians only if they are certified as participants accepting Medicare. Brief visits to monitor the efficacy of prescribed medications are covered. Medicare

also covers individual and group therapy, therapeutic activity programs, family psychotherapy and counseling, consumer education services and lab testing. Substance use treatment in an outpatient treatment center is covered if the treatment center has agreed to participate in the Medicare program. Individuals must actively enroll in Part B and must pay a monthly premium. For low-income individuals who qualify, Medicaid pays the monthly premium.

Medicare also covers partial hospitalization programs including those that offer intensive psychiatric treatment on an outpatient basis, with an expectation that the person's psychiatric condition and level of functioning will improve, relapse will be prevented and re-hospitalization avoided. Partial hospitalization programs are located in hospital outpatient departments or community mental health centers. These programs include diagnostic services, individual and group therapy, therapeutic activities, family counseling regarding the consumer's condition, consumer education, and the services of social workers, psychiatric nurses and occupational therapists.

Partial hospitalization services must be provided under the direct supervision of a physician according to an individualized treatment plan, and the services must be essential for treatment of the person's condition.

Medicare Part C

Medicare Part C is a managed care plan referred to as Medicare Advantage. Medicare Advantage is not available statewide, but is offered in most urban areas of Texas. Geographic availability depends on the willingness of managed care organizations to provide it. Part C includes benefits from both Part A and Part B. Enrollees volunteer to participate in Part C.

Medicare Part D

Medicare Part D provides prescription drug coverage. The program was created in 2003 and is available to all Medicare eligible individuals, but requires premium payments that vary depending on the plan the enrollee selects. Medicare drug plans must cover antidepressant, anticonvulsant and antipsychotic medications that may be necessary for mental health treatment. For dual eligible enrollees in both Medicare and Medicaid, prescription drug benefits are paid primarily under Part D, but Medicaid continues to pay some drugs not covered by Part D.

Medicare and Medicaid (Dual Eligibility)

People who are eligible for both Medicare and Medicaid, commonly referred to as being dually eligible, typically have lower income and greater functional disability than other Medicare beneficiaries. Elderly people who are eligible for both programs are more likely to have physical health problems such as diabetes, as well as mental illness. People less than 65 years of age who meet eligibility criteria for both Medicare and Medicaid are less likely to have physical health problems but much more likely to have mental illness.[351] If a person is eligible for both Medicare and Medicaid, Medicaid pays the Medicare cost-sharing obligations and provides certain Medicaid services not covered under Medicare.

Regulating Private Insurance Coverage for Behavioral Health Conditions

Both federal and state laws and regulations specify requirements for mental health and substance use coverage that apply to insurers selling health insurance in Texas. Prior to enactment of these legal provisions, health insurance plans typically excluded or significantly limited coverage for mental health and substance use treatment. Over time, however, national and state policymakers have enacted several laws that take various approaches to improving coverage for behavioral health services. While federal laws take a broader approach, Texas laws are more specific and apply to different types of health plans.

Despite the significant improvements in both access to coverage and benefit plan design, however, the myriad of health insurance laws still leaves gaps in coverage for some people and services. This section provides an overview of both state and federal requirements for insurance plans and related cost data for mental health benefits and services.

Federal Insurance Requirements

Federal requirements for health insurance coverage of mental health and substance use fall under three separate laws: the Mental Health Parity Act (MHPA) of 1996, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, and the Patient Protection and Affordable Care Act (ACA). The first two laws are designed primarily to address the fact that insurance benefits for mental health and substance use typically restricted coverage significantly by imposing lower annual or lifetime dollar limits, restricting the number of days of hospital coverage or the number of outpatient visits, and increasing cost-sharing requirements for mental health services. Both laws require parity benefits in health plans that offer mental health insurance coverage, but they do not require health plans or employers to include coverage of mental health services. The ACA built on the parity laws and will require mental health services be included in most insurance plans. More information on the ACA is available in Section 2: National Context and Section 3: Texas Environment.

Mental Health Parity Act of 1996

The Mental Health Parity Act (MHPA) of 1996 prohibits group health plans and insurers that provide mental health coverage from establishing annual or lifetime dollar limits on mental health coverage that are any lower than limits applicable to medical and surgical services. The requirements apply to private-sector employee benefit plans (including self-funded plans) and to insurers selling fully insured group plans. Because of exclusions under the Employees Retirement and Income Security Act (ERISA), the law does not apply to governmental plans or coverage offered under individual benefit plans.

The law also provides a specific exemption for a small-employer plans offered to groups of two to 50 employees. In response to concerns that the law would create a significant premium cost increase, the MHPA also includes a provision that allows group health plans that experience a cost increase of at least 1% to claim an exemption from the parity requirements.

Mental Health Parity and Addiction Equity Act

In 2008, Congress enacted the Mental Health Parity and Addiction Equity Act (MHPAEA) to further expand the mental health parity requirements under the 1996 law and include coverage requirements for substance use. In addition to the restriction on annual or lifetime limits enacted under the MHPA in 1996, the 2008 law prohibits insurers or health plans from imposing limits on the frequency of treatment, number of visits, days of coverage or any other limits on the scope of coverage or duration of treatment for mental health services that are any more restrictive than the limits imposed on coverage of medical or surgical services for physical care.

The law also amended the definition of small employer to include firms with only one employee to provide consistency with state laws that include single-employee firms in their small-group definition.[352] As with the 1996 act, the more recent law exempts individual insurance plans and does not require group health plans to cover mental health and substance use conditions, but its provisions do apply to group plans that offer these benefits. The law also requires Medicaid managed-care plans and CHIP plans to comply with certain requirements, but only if they choose to include mental health services. Medicare plans are exempt from both the 1996 and 2008 laws.

State Insurance Requirements

State legislative and regulatory requirements for mental health and substance use insurance benefits have been enacted over an extended period of time and have resulted in a confusing matrix of benefits that is often difficult for consumers to navigate. The current benefit requirements vary based on the diagnosis, the age of the person, the type of provider and the type of health plan under which he or she is insured.

Following is a brief summary description of the state-mandated benefit requirements in Texas for services related to mental health and substance use treatment.[353]

- Mental health parity: A health plan that provides mental health benefits may not include an annual dollar limit or a lifetime aggregate dollar limit for mental health benefits that is lower than any limits placed on medical or surgical benefits. If no limits apply to medical benefits, none may be imposed on mental health benefits.[354]
- Serious mental illness: A group health plan must provide inpatient and outpatient treatment for coverage of serious mental illness. Plans may not include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits and must include the same limits, deductibles and coinsurance factors for serious mental illness as for physical illness. Small employers must be offered coverage for serious mental illness, but have the right to reject the benefit.[355]
- Autism spectrum disorder: Health plans must provide coverage for autism spectrum disorder from the date of diagnosis through age nine. Coverage must include all generally recognized services prescribed by the enrollee's primary care physician.[356]
- Acquired brain injury: A small-employer health plan must include coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment, neurofeedback

therapy, remediation, post-acute transition services and community reintegration services necessary as a result of an acquired brain injury.

Health benefit plans other than small-employer health benefit plans must:

- Include coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment, neurofeedback therapy and remediation required for and related to treatment of an acquired brain injury.
- Include coverage for post-acute transition services, community reintegration services including outpatient day treatment services, and other post-acute care treatment services necessary as a result of and related to an acquired brain injury.
- Not include any post-acute care treatment in any lifetime limitation on the number of days of acute care treatment covered under the plan. Any limitation imposed under the plan on days of post-acute care treatment must be separately stated in the plan.
- Include the same payment limitations, deductibles, copayments and coinsurance factors for coverage applicable to other similar coverage provided under the health benefit plan.
- Include coverage for reasonable expenses related to periodic reevaluation of the care of a covered individual who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date.[357]

- Chemical dependency: Benefits for the necessary care and treatment of chemical dependency must be provided on the same basis as benefits for physical illness. Services provided in a chemical dependency treatment facility must be provided on the same basis as services provided in a hospital.[358]
- Mental and nervous conditions with demonstrable organic disease: Individual health plans must include coverage of mental, emotional or functional nervous conditions with demonstrable organic disease.[359]
- Psychiatric day treatment facility: Group health plans that provide benefits for the treatment of mental illness in a hospital must include benefits for treatment in a psychiatric day treatment facility. Psychiatric day treatment benefits must be equal to at least one-half of the coverage provided for treatment in a hospital.[360]
- Crisis stabilization and residential treatment facility for children and adolescents: Any health plan that provides benefits for treatment of mental or emotional illnesses when confined in a hospital must also include coverage for treatment in a crisis stabilization unit or residential treatment center. Benefits may not be less favorable than treatment provided in a hospital or inpatient program.[361]
- Continuation of coverage for adults with mental or physical disabilities: A dependent child who reaches the maximum age limit under a parent's policy must be allowed to remain in the policy if the child is incapable of self-sustaining employment due to mental or physical disabilities, and is dependent on the insured for support.[362]

Texas' benefit requirements for mental health and substance use coverage do not apply to all health plans, but instead vary based on whether the plan is a group, individual or association plan, fee-for-service/preferred provider plan or health maintenance organization, a state-mandated plan or consumer choice plan. When enacting each of the statutes described above, the Texas Legislature identified which plans are subject to the benefit requirement.

Figure 68 summarizes the applicability of each benefit requirement by type of plan. "Yes" indicates the benefit is required for that type of policy; "No" indicates the benefit is not required; and "Offer" means the health plan must offer the benefit as an option, but the purchaser has the right to accept or refuse the benefit.

Figure 68. State Mental Health and Substance Use Insurance Requirements

Benefit Description	Fee For Service/Preferred Provider Plans								HMO					
	State Mandated Plan				Consumer Choice Plan				State Mandated Plan			Consumer Choice Plan		
	Individual Plans	Small Employer Plans	Large Employer Plans	Association Plans	Individual Plans	Small Employer Plans	Large Employer Plans	Association Plans	Individual Plans	Small Employer Plans	Large Employer Plans	Individual Plans	Small Employer Plans	Large Employer Plans
Psychiatric day treatment facility	No	Offer	Offer	Offer	No	No	No	No	No	Offer	Offer	No	No	No
Crisis stabilization and residential treatment for children and adolescents	No	Yes	Yes	Yes	No	No	No	No	No	Yes	Yes	No	No	No
Mental health parity	No	No	Yes	Yes	No	No	No	No	No	No	Yes	No	No	No
Mental/nervous conditions with demonstrable organic disease	Yes	No	No	No	No	No	No	No	No	No	No	No	No	No
Serious mental illness	No	Offer	Yes	Yes	No	Offer	Yes	Yes	No	Offer	Yes	No	Offer	Yes
Autism spectrum disorder	No	Yes	Yes	Yes	No	No	No	No	No	Yes	Yes	No	No	No
Acquired brain injury	Yes	Yes	Yes	Yes	No	No	No	No	Yes	Yes	Yes	No	No	No
Chemical dependency – benefits	No	Yes	Yes	Yes	No	No	No	No	No	Yes	Yes	No	No	No
Chemical dependency – treatment facility	No	Yes	Yes	Yes	No	No	No	No	No	Yes	Yes	No	No	No

Source: Texas Department of Insurance. (n.d.) Your Health Care Coverage. Retrieved from www.tdi.texas.gov/pubs/consumer/cb005.html

Health Plan Benefit Requirements for State, University and Public School Employees

In addition to the mandated requirements described above for plans regulated by the Texas Department of Insurance (TDI), the Texas Legislature also determines benefit requirements for health plans provided to state employees, state-supported university employees, and public school employees. However, rather than prescribing specific benefits, state law generally requires the agency administrators of these plans to determine the appropriate benefits. State law specifically exempts these plans from provisions that apply to other state-regulated plans unless the legislature determines otherwise.

With regard to mental health and substance use coverage, these health plans are only required by law to provide benefits for serious mental illness that are at least as extensive as benefits provided for any other physical illness. However, all plans include services for the treatment of substance use, as well as more extensive benefits that go beyond the requirements for serious mental illness. These plans are re-negotiated on a periodic basis, and benefit provisions are subject to change each time the plans are renewed or renegotiated.

Texas Insurance Utilization and Premium Cost Data

TDI collects annual benefit utilization and claims cost data from health insurers and HMOs on most, but not all, mandated benefit requirements. Data reported by health insurance carriers is based on claims data for fully insured, state-regulated health plans. Figure 69 provides a summary of the most recent data available for group mental health and substance use benefit requirements.

Figure 69. Texas Group Health Insurance Claims and Premium Data, 2009

Benefit Requirement	Number of Claims Paid	Claims Cost as a Percent of all Claims Paid	Estimated Premium for Enrollee-Only Coverage	Estimated Annual Premium for Family Coverage
Acquired brain injury	203,194	0.33%	$6.99	$19.90
Substance use	27,867	0.23%	$9.01	$22.66
Psychiatric day treatment	30,426	0.10%	$3.21	$7.78
Serious mental illness	210,004	0.44%	$20.09	$49.43

Source: Texas Department of Insurance. (2009). Texas mandated benefit cost and utilization summary report: October 2008 – September 2009 reporting period. Retrieved from www.tdi.texas.gov/reports/life/documents/lhlmanbenrept09.pdf

Section 6. Best Practices and Policy Priorities

This section discusses behavioral health best practices and current national and state policy priorities.

Best Practices

The term "best practices" encompasses both "evidence-based" and "promising" practices. Evidence-based practices are prevention or treatment interventions that have undergone rigorous scientific evaluation. The Substance Abuse and Mental Health Services Administration has developed the National Registry of Evidence-based Programs and Practices (NREPP). It is a searchable online registry of interventions supporting mental health and substance use prevention and treatment. The registry can be found at **www.nrepp.samhsa.gov/Index.aspx.**

Promising practices are those that show positive outcomes but do not yet have the same level of research support. Some examples of best practices utilized in the state are described below. Further information on behavioral health best practices, including a searchable inventory of best practices offered by stage agencies, is available at **www.utexas.edu/research/cswr/tbhc.**

Best Practice: Recovery and Peer Support

Recovery from mental illness and substance use is possible and is the goal. Effective treatments exist for child and adult mental health and substance use disorders. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery from mental illness and substance use as:

> *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*[363]

State and local mental health agencies are adopting a recovery orientation at a variety of levels, including policy and planning, the provision of treatment and supports, and promotion of peer support activities. The substance use field is shifting from an acute care model of treatment to a recovery-oriented system of care approach as well.[364] Following are some Texas initiatives promoting recovery oriented systems.

Peer Support and Certified Peer Support Specialist Training

Certified peer support specialists are an economical and effective way to address the mental health workforce shortage in Texas.[365] Many agencies have difficulty in recruiting and retaining mental health professionals. Peer specialists are an additional pool of mental health workers who can augment hard-to-find licensed staff. They do not replace professionals but their participation on the care team provides a different perspective. When a peer specialist provides support services, the licensed professional is available to focus on the clinical service delivery for which he or she was trained. In addition,

peer specialists' personal experience with and recovery from mental illness provides a perspective that other mental health professionals cannot offer.[366]

Peer specialists assist agency administrators, clinicians, consumers and their families on aspects related to treatment. Through group facilitation, one-on-one interaction, and crisis intervention, peer specialists provide information, foster consumer empowerment, and facilitate links to services. Additionally, they educate the community about mental illness, recovery, strength-based approaches to service delivery and consumer involvement.

At least 26 local mental health authorities (LMHAs), six state psychiatric hospitals and the Veteran's Administration Heart of Texas Healthcare Network utilize certified peer support specialists.[367] Since the certification process began in 2010, over 240 certified peer specialists have been trained in Texas. [368]

Family Partner Certification

Similar to the peer specialist role, family partners are individuals with experience parenting a child with mental, emotional or behavioral health disorders and have had personal involvement with the public mental health system. A family partner provides information and support to other parents in similar circumstances. Via Hope developed the family partner certification curriculum in collaboration with state, regional and national stakeholders and has trained more than 60 family partners.[369]

Youth Outreach

The youth outreach strategy supports programs for youth living with mental illness**.** The program was built through input from youth focus groups. Youth representatives received training during weekend youth advocacy retreats to learn about mental health in general, how to advocate for themselves and others, and how to support an individual with mental health issues. The youth initiative also provides support to student leaders of mental health awareness groups on college campuses.

Statewide Consumer Engagement

DSHS provides funding to seven consumer-operated service providers (COSPs) to deliver services such as peer support, outreach, education and advocacy. COSPs are independent organizations operated and governed by individuals in recovery. Via Hope is responsible for providing technical assistance to the seven COSPs to establish sustainability plans, further their organizational development, and help disseminate information to increase capacity of COSPs across Texas.[370] The COSPs partner with LMHAs to provide services.

Learning Communities

Via Hope and the Center for Social Work Research at The University of Texas at Austin partnered to develop the 2011 Peer Specialist and 2012 Recovery Focused learning communities. Fundamental to these learning communities is the Learning Model combined with the Model for Improvement.[371] Both models provide programmatic structure that allows for deep learning through the use of expert mentors and the development of a shared learning community.

Recovery Institute

Building on the lessons gleaned from the learning communities, Via Hope created the Recovery Institute in 2011 to move theory to practice by promoting and implementing recovery-based activities among provider organizations. The Recovery Institute is a year-long commitment to participate in the intensive recovery-focused training and technical assistance program. It utilizes webinars, conference calls and more in-depth and application-based activities such as leadership academies. The most advanced technical assistance involves the development of innovative recovery practices such as peer support services and person-centered recovery planning.[372]

Wellness Recovery Action Plan (WRAP®) Self-Directed Planning

An example of person-centered recovery planning is a Wellness Recovery Action Plan (WRAP®), a national evidence-based practice. Through WRAP®, consumers develop their own wellness tools, identify triggers for symptoms and ideas to manage them, develop strategies to address personal early warning signs and create a crisis plan.[373]

Recovery-Oriented Systems of Care for Substance Use

DSHS is also supporting the recovery-oriented systems of care (ROSC)[374] for substance use planning and service delivery systems change. A ROSC is a network of organizations, agencies, and individuals that coordinates services at the community level to prevent, intervene and treat substance use problems and disorders. To date, 23 Texas communities are initiating local ROSCs.

Military Veteran Peer Support

Military veterans continue to experience the stigma often associated with seeking mental health services. Recognizing the challenge that veterans and their families experience post-deployment, DSHS created a peer-to-peer program through which veterans facilitate support groups of their peers.[375] Operation Resilient Families (ORF) is an education and support program for veterans of Iraq and Afghanistan and their families. The program is an eight-session peer-led group focused on enhancing family resilience and preventing readjustment challenges. ORF teaches participants how to use communication and problem-solving skills and develop a personalized family resilience plan to address specific family circumstances. Through a contract with DSHS, NAMI Texas delivers training to peer-led teams, consisting of a veteran and a family member with war zone post-deployment experience. ORF is offered through designated community mental health centers across Texas.[376]

Best Practice: Integrated Primary, Mental Health and Substance Use Care

Across the country, integrated health care has emerged as an effective strategy for treating the whole person by addressing primary, mental health and substance use problems in a systemic and coordinated manner. Using primary care settings for behavioral health services enhances access to services, reduces stigma to seeking care, is cost-effective and has good outcomes.[377] Additionally, using behavioral health settings and integrating primary care services makes integrated health care available to many

who would not otherwise receive it. Models of care vary based on whether the covered population has low or high physical health and behavioral health needs. They can be as simple as co-located arrangements in which the primary care and behavioral health professionals work together in the same office or interagency partnerships in which the care of consumers is shared between primary care and behavioral health providers, or as complex as full integration at the organizational level. Rural and other underserved communities have tailored integrated care approaches to serve sparsely populated geographic areas and culturally diverse populations.

Communities across Texas have implemented integrated care models through federally qualified health centers (FQHCs) and other health clinics, some in partnership with LMHAs. LMHAs in Austin, Fort Worth, Lubbock and San Antonio have received federal SAMHSA grants to develop bi-directional integrated care for persons with severe mental illness.

In 2009, HB 2196, 81st Texas Legislature, required the Health and Human Services Commission to recommend best practices in policy, training and service delivery to support integrated care service delivery in the state. The final report, *Integration of Health and Behavioral Health Workgroup: Report to the 81st Texas Legislature*, identifies barriers and specific policy strategies to broaden integrated physical and behavioral health care in Texas. These include recommendations to:[378]

- Create a state health care integration leadership council.
- Create and support a focus on health care integration in Texas.
- Support local health care integration planning.
- Address systemic barriers to health care integration, including a continued evaluation of statutory and administrative provisions, policies and procedures, and reimbursement practices that inadvertently deter health care integration.
- Encourage adoption of confidential health information technology and information sharing.
- Develop systems for meaningful and functional outcome measurement and tracking.
- Support routine health and behavioral health screening during assessments.
- Develop policies to address training, continuing education and workforce needs.
- Implement integration efforts as part of federal health reform requirements.[379]

Best Practice: Prevention and Early Intervention

Mental illness prevention is defined as a "proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles."[380] For persons of all ages, early identification and treatment of emerging mental health and substance use problems can help with recovery, prevent mental health problems from worsening, and mitigate the impact of serious and disabling conditions.

Fifty percent of all lifetime cases of mental illness are apparent by age 14 and 75% are apparent by age 24.

Early intervention for young children with mental health issues supports healthy development and improves family life. Children who enter kindergarten with effective social skills have an easier time developing relationships with peers and do better in school. Young children who

receive effective, age-appropriate mental health services and supports are more likely to complete high school, have fewer contacts with law enforcement, and improve their ability to live independently and productively.[381] Without intervention, child and adolescent disorders frequently continue into adulthood. Fifty percent of all lifetime cases of mental illness are apparent by age 14 and 75% are apparent by age 24.[382] Screening and assessment for behavioral health conditions can occur through many venues such as primary care, mental health providers, early childhood intervention, schools, jails, and juvenile detention centers, among others.

In Texas, the annual behavioral health indirect cost due to heightened juvenile and adult criminal justice involvement, special education, mental and physical health care, substance use, and lost productivity to society is estimated at over $5.2 billion.[383] By investing in prevention and early intervention strategies and identifying and treating people when concerns first arise, Texas has the opportunity to avoid the high costs associated with untreated mental illness and reap the benefits of a healthy, productive workforce.

Several DSHS programs focus on substance use prevention and early intervention, including the following:

- Substance Abuse Services funds 11 prevention resource centers across the state. These centers provide communities, including schools, with prevention materials and information, resources and expertise.[384]
- School and community-based programs: 200 school and community-based programs statewide are funded to prevent the use and consequences of alcohol, tobacco and other drugs among Texas youth and families. These programs provide evidence-based curricula and effective prevention strategies.[385]
- The Texas Alliance of the Partnership for a Drug-Free America generates millions of dollars in advertising and media exposure to encourage Texas youths to make wise choices about alcohol and other drugs through student book covers and posters, shopping center kiosks with anti-drug information, and a billboard campaign targeting marijuana use, among others.[386]
- In 2011, HB 1386 (82nd regular session) required DSHS, in coordination with the Texas Education Agency, to recommend best-practice-based early mental health intervention and suicide prevention training programs for implementation in public elementary, junior high, middle and high schools. Each school district may, but is not required to, use these training programs.[387]
- In FY 2014, DSHS plans a border health initiative to address the specific needs of the rural border communities by providing integrated prevention and intervention services and access to a continuum of behavioral health services, including substance use prevention, intervention and treatment and mental health promotion and treatment, to members of the rural border community who have, or are at high risk of developing, substance use disorders.

Best Practice: Seclusion and Restraint Alternatives

Seclusion and restraint is the use of physical force, restriction of movement, involuntary use of medication or isolation to manage behavior. Seclusion and restraint methods are used in settings such as psychiatric hospitals, criminal justice settings, residential treatment facilities and schools.[388] The practice can be traumatic and dangerous to

individuals and staff, causing physical and psychological harm, and even death. At a minimum, its use can conflict with a positive therapeutic environment and hinder consumer recovery.[389]

In SB 325, the 79th Texas Legislature created the Behavioral Management Work Group to review and provide recommendations on best practices in policy, training, safety and risk management related to reducing seclusion and restraint use. The report of the workgroup, issued in 2006, is available at **www.hogg.utexas.edu/.**

In 2007, Texas was awarded a federal grant from SAMHSA for the reduction or elimination of restraint and seclusion in four state psychiatric hospitals in Austin, Big Spring, San Antonio and Vernon/Wichita Falls. The project, State of Texas Alternatives to Restraint and Seclusion (STARS), was designed to advance evidence-based infrastructure improvements in these four state psychiatric hospitals to reduce and ultimately end the use of restraint and seclusion in the treatment of consumers with mental health disorders, including those with co-occurring substance use disorders or developmental disabilities. The project focused its efforts on the most vulnerable of these hospitalized individuals, including children, adolescents and older adults.[390]

Through the STARS grant, Texas has made significant improvements in the culture of care at the state hospitals, most notably reflected in reductions in both the numbers of incidents of restraint or seclusion, the numbers of individuals involved, and the length of time spent in restraint or seclusion per incident.[391] One of the products resulting from the STARS grant was a toolkit designed to help reduce seclusion and restraint in any setting. *Creating a Culture of Care: A Toolkit for Creating a Trauma-Informed Environment* can be found at **www.dshs.state.tx.us/cultureofcare**.

The Hogg Foundation for Mental Health has been actively engaged in restraint and seclusion reduction efforts. Past initiatives include statewide trainings, seminars, and publications. The foundation continues with a focus on restraint and seclusion reduction through facilitation of the statewide leadership group as well as grants awarded to two organizations to facilitate restraint reduction efforts in residential treatment facilities and state supported living centers.

Best Practice: Trauma-Informed Care

Many people seeking behavioral health treatment or who are in other programs such as homeless and domestic violence shelters, foster care, or juvenile or criminal justice systems have histories of physical and sexual abuse and other types of trauma-inducing experiences. Left unrecognized and untreated, these traumatic experiences can lead to mental health problems, chronic health conditions, substance use and eating disorders, as well as contact with the criminal justice system.[392]

Trauma-informed care specifically addresses the consequences of trauma on an individual.[393] Treatment programs help persons recognize:[394]

- Survivors' need to be respected, informed, connected and hopeful regarding their own recovery.
- The interrelation between trauma and symptoms of trauma, such as substance use, eating disorders, depression and anxiety.

- The need to work in a collaborative way with survivors, family and friends of the survivor, and human services agencies in a manner that will empower survivors and consumers.

Trauma-informed care changes the paradigm from asking, "What is wrong with you?" to asking, "What happened to you and how can we support your recovery?" State agency trauma-informed care initiatives include the following:

- DSHS has been awarded a SAMHSA Jail Diversion and Trauma Recovery Program grant to support people with post-traumatic stress disorder (PTSD) and other trauma-related disorders. DSHS' initiative uses the Seeking Safety model of trauma treatment and is projected to serve 180 persons per year. The eligible population includes adults with PTSD and related disorders, with priority for military veterans, especially those from operations Iraqi Freedom and Enduring Freedom.[395]
- Partnering with the Department of Aging and Disability Services (DADS), the Hogg Foundation for Mental Health is providing training and technical assistance on trauma-informed care to service providers supporting individuals with intellectual and developmental disabilities. Training was provided for facility staff and community service providers at two state supported living centers in February 2012. The training and technical assistance will continue through the two-year grant period.
- HB 1151, 81st Texas Legislature, requires eight hours of trauma-informed care training for Child Protective Services (CPS) case workers and supervisors, two hours for other CPS staff, and three hours for direct care givers.[396] The Texas Legislature renewed its commitment to trauma-informed care by authorizing the Department of Family and Protective Services (DFPS) to not only maintain its own trauma-informed care program, but to assist in the development of similar programs throughout the child welfare system if funding is available.[397]

Best Practice: Jail Diversion

Jail diversion services are intended to divert people with serious behavioral health disorders who are frequently charged with crimes (typically misdemeanors like trespassing or disorderly conduct) from further involvement in the criminal justice system.[398] Jail diversion services are considered critical strategies for preventing people with mental illness who commit crimes from entering or unnecessarily remaining in the criminal justice system. Services vary widely because local systems differ in terms of their size, need and available treatment resources. Jail diversion may entail treatment as a condition of bail, deferred prosecution, deferred sentencing or treatment as a condition of probation following a guilty plea.[399]

A number of urban communities in Texas have specialty mental health or substance use courts with court dockets focused on this population. In these situations, the court maintains judicial oversight of the person's participation in required treatment. Additional information on jail diversion services is described in Section 4: Public Behavioral Health Services in Texas.

Best Practice: Outpatient Competency Restoration

Outpatient competency restoration (OCR) is an effective alternative to lengthy jail stays and costly hospital commitments for some individuals with mental illness or intellectual disabilities. Competency restoration is the criminal justice system process used when individuals are charged with crimes but deemed incompetent to stand trial. To be considered restored and competent to stand trial, a defendant must be able to consult with his or her defense lawyer and have a rational and factual understanding of the legal proceedings.[400]

In 2007, SB 867, 80th Texas Legislature, established OCR pilots at four initial sites in Travis, Bexar, Dallas and Tarrant counties. Before participating in the pilot projects, defendants are fully screened to ensure they do not pose a significant risk to themselves or others in the community. As of March 2012, over 600 individuals had been provided restoration services through the OCR pilot sites at an average cost of $140 per person per day, compared to an average cost of $401 per person per day for inpatient hospital restoration. About 70% of the defendants participating in the pilots either were restored to competency or improved enough to be enrolled in community mental health services and have their charges dropped.[401]

The DSHS Continuity of Care Task Force Report recommended expansion of outpatient restoration services.[402] Budget Rider 78 (82nd regular session) promoted by advocates subsequently directed DSHS to allocate $4 million each year to support expanding the number of pilot sites.[403] Additional information is available in Section 4. Public Behavioral Health Services in Texas.

Best Practice: Child and Family Mental Health System of Care

The system of care approach is the philosophical and organizational framework for the collaborative, systemic planning and delivery of child and family mental health services. Established in practice and research for over 25 years, systems of care have been proven nationally to result in better child and family outcomes, increase access to services and supports and be cost-effective.[404]

Programs using this approach provide coordinated care that includes community-based services and supports for children and their families. This model is based on a federal initiative that emphasizes the core value of services that are community based, child centered and family focused, and culturally competent.

Several Texas communities have received state and federal grants to support system of care programs, which receive technical support and training through HHSC's Office of Program Coordination for Children and Youth. HHSC recently received a SAMHSA grant to support the statewide expansion of the system of care approach. The Achieving Successful Systems Enriching Texas Initiative (ASSET) grant is a joint project of HHSC, DSHS and the Center for Social Work Research at The University of Texas at Austin. Further information is available at **www.txsystemofcare.org/about-us.**

Best Practice: Telemedicine/Telehealth

Telemedicine (or more broadly, telehealth) is the use of technology to deliver health care services, including services for mental health and substance use. It is typically used in Texas to provide services to rural or underserved areas using technology to connect a remote site such as a clinic or school where the consumer is located and a hub site where the consulting professional provider is located.

Telehealth increases access to care by maximizing the use of available behavioral health care professionals, especially for Texans living in federally designated mental health professional shortage areas. For some consumers, the use of telehealth eases the stigma and embarrassment of seeking behavioral health care.[405] Community health and mental health centers are using technology to increase access to specialists. In addition, the University of Texas Medical Branch (UTMB) at Galveston has a well-established telemedicine program that provides services to multiple settings, including Texas Department of Criminal Justice (TDCJ) facilities, community health and mental health centers, and schools. Further information on UTMB's extensive telemedicine program is available at **telehealth.utmb.edu/presentations/Benefits_Of_Telemedicine.pdf.**

The Statewide Health Coordinating Council reports that telehealth holds the potential for the greatest economic impact on rising health costs in Texas during this century.[406] Since Texas Medicaid began providing telemedicine medical services in 1998, services have been modified and expanded through each legislative session from 2001 to 2011. These modifications include provisions to expand eligible providers, locations and pilot projects. The total number of distant and consumer site providers using telemedicine increased 84% from FY 2007 to FY 2009. The number of clients receiving telehealth services increased by 233% from 2007 to 2009, while Medicaid costs for telehealth services increased by 246%. These cost increases are attributed to expanded coverage of telehealth services, improved tracking of telehealth services, and other telehealth network expansion initiatives aimed at improving access to specialty and subspecialty care in Medicaid.[407]

Best Practice: Suicide Awareness and Prevention

Approximately 38,000 people die by suicide each year in the United States. In 2010, 2,891 Texans committed suicide.[408] In Texas, suicide is the 10th leading cause of death overall, the second leading cause of death among young adults ages 25-34, and third leading cause of death among youth ages 15-24.[409] Data collected from 2,171 Texas high school students through the Youth Risk Behavior Survey in 2011 revealed that 29% of students identified themselves as depressed, 16% of students were actively considering suicide and 11% of students were likely to attempt suicide.[410]

Although there is no one cause of suicide, 90% of those who die by suicide have an underlying mental health or substance use condition. White males have the highest suicide rates, but suicide cuts across all ethnicities, ages, races and genders. Recent increases have been reported in suicide among African American males and middle-aged women.[411]

Suicide in Texas is a serious public health concern and one that could be addressed effectively through comprehensive and coordinated prevention practices. The Texas Suicide Prevention Council is a collaborative effort between local suicide prevention coalitions and state agencies to implement an effective suicide prevention plan in Texas. The council's activities include an informational website, suicide prevention trainings, an annual suicide prevention conference, bilingual information packets, and generating public awareness. The council, along with Mental Health America of Texas, has published a list of Texas statutes that relate to suicide prevention, services and reporting. The council also offers free downloadable resources about suicide prevention and intervention. For more information visit the Texas Suicide Prevention website at **www.texassuicideprevention.org**.[412]

The American Foundation for Suicide Prevention (AFSP) Central Texas Chapter is another suicide prevention resource available for Texans. AFSP is a national nonprofit dedicated to understanding and preventing suicide through research, education, advocacy and outreach. The AFSP website provides information on suicide prevention, volunteer opportunities, educational resources, research grants and support for individuals surviving a suicide loss.[413] More information can be found at **www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=1.**

DSHS lists the following toll-free, 24-hour hotlines available to anyone experiencing a suicidal or emotional crisis:[414]

- National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
- Red Nacional de Prevencion del Suicidio: 1-888-628-9454
- Veterans Suicide Prevention Hotline: 1-800-273-8255 or text 838255
- The Trevor Project Hotline for Lesbian, Gay, Bisexual, Transgender or Questioning Youth (LGBTQ): Trevor Lifeline – 1-866-488-7386

Texas LMHAs also operate crisis hotlines. For a list of all Texas LMHA crisis hotline numbers, go to **www.dshs.state.tx.us/mhsa/lmha-list/**.

Section 7. Mental Health Workforce Shortages

One of the most significant challenges facing health care today is the growing shortage of health care providers. By 2020, national predictions estimate a shortage of more than 100,000 doctors and 300,000 nurses.[415] While the number of professionals grows at a lower rate than the nation's population, the problem is compounded by the fact that, as Americans continue to live longer, they also develop more complex physical and mental health conditions, requiring more care and further increasing the demands on existing workers.

Texas is not immune to this problem. As illustrated in Figure 70, the state's supply of professionals providing mental health and substance use services has failed to keep pace with the population growth. Health care professionals struggle to meet the current health care needs of Texans, and future population growth will place more strain on an overburdened workforce.

This problem is particularly acute for mental health services, which account for the most severe health professional shortages in the state. The state ranks well below national averages in the number of professionals providing mental health services per 100,000 residents. In 2010, the Department of State Health Services (DSHS) reported less than one-third (29.8%) of children with severe emotional disturbance and only 34% of adults with serious and persistent mental illness received treatment through the community mental health system.[416]

Workforce shortages deprive Texans of critical services they need for wellness and recovery, and contribute to the use of more expensive and less effective services provided in emergency departments or through criminal justice programs. Addressing this problem will require a significant investment in programs to support the mental health workforce and a long-term strategy for ensuring Texans have access to the services they need to live productive lives.

This section of the report provides an overview of the current workforce of mental health professionals and the challenges they face in providing services to a growing population with complex conditions. It includes strategies for addressing the problem and a discussion of future needs that must be addressed to ensure Texans have access to the mental health services they need.

Figure 70 demonstrates workforce ratio trends for select mental health professional types from 2000-2009.

Figure 70. Mental Health Workforce Trends in Texas

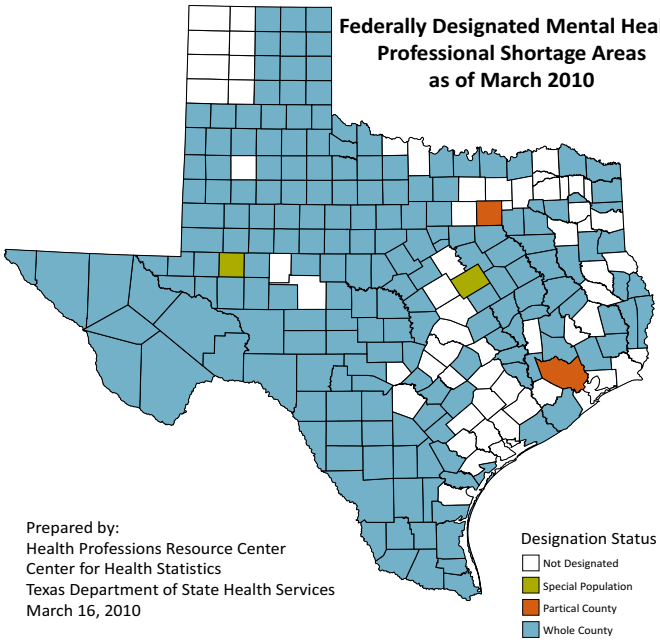
Year	Texas Population	Psychiatrists	# of Psychiatrists per 100,000 Residents	Psychologists	# of Psychologists per 100,000 Residents	Social Workers	# of Social Workers per 100,000 Residents	Marriage & Family Therapists	# of Marriage & Family Therapists per 100,000 Residents	Licensed Professional Counselors	# of LPCs per 100,000 Residents
2000	20,945,963	1,422	6.79	5,044	24.8	14,549	69.46	3,417	16.31	10,036**	48.5**
2009	24,782,302	1,634	6.59	6,547*	25.8*	16,574	66.88	2,789	11.26	13,352*	52.6*

*Data are from 2010
**Data are from 2001.
Source: "Highlights: The Supply of Mental Health Professionals in Texas -2010." Texas Department of State Health Services, April 2011. Web. July 2, 2012.

Workforce Availability in Texas

While the population in Texas has increased and become more diverse and health care needs have grown more complex, the supply of mental health professionals has not kept pace.[417] In 2009, 173 out of 254 Texas counties were designated as health professional shortage areas for mental health by the federal government.[418] In that same year, 102 Texas counties did not have a psychologist, 48 counties did not have a licensed professional counselor, and 46 counties did not have a single licensed social worker.[419]

Figure 71. Federally Designated Mental Health Professional Shortage Areas as of March 2010



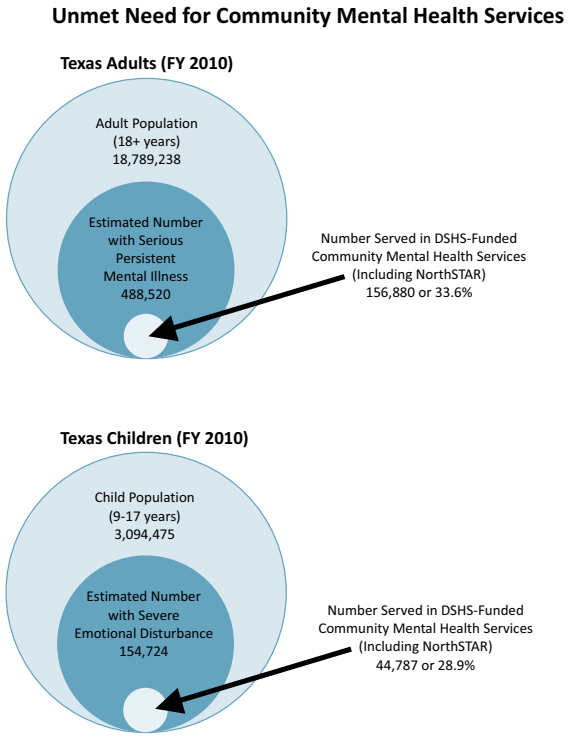
Source: Hogg Foundation for Mental Health and Methodist Healthcare Ministries. (March 2011). Crisis point: Mental health workforce shortages in Texas. Retrieved from www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf

Factors that contribute to and exacerbate the mental health workforce shortage in Texas include:[420]

- An aging workforce that is beginning to retire.
- Recruitment and training challenges for mental health professionals.
- Lack of Texas mental health professional internship sites.
- Inadequate pay and reimbursement rates in the public mental health system.
- Lack of cultural and linguistic diversity in the workforce, causing a significant shortage of mental health providers with the knowledge, training and skills to serve people who speak languages other than English or are of racial or ethnic minority populations.
- Increasing demand for behavioral health services.

Culturally competent and linguistically diverse mental health professionals are particularly difficult to access in Texas.[421] As of 2009, 64% of all psychiatrists were white, 3.5% were African American, and 12.4% were Hispanic.[422] A 2011 report by the Hogg Foundation for Mental Health and Methodist Healthcare Ministries states that "without cultural competency in treatment, recovery and wellness can remain unreachable for many people with mental illness." The problem is especially apparent in Hispanic communities along the border, where residents juggle two languages and cultures. Urban areas like Houston and Dallas struggle to meet demands of a diverse population that often includes a large number of immigrants and minorities.

Figure 72 Unmet Needs for Community Mental Health Services



Source: Hogg Foundation for Mental Health and Methodist Healthcare Ministries. (March 2011). Crisis point: Mental health workforce shortages in Texas. Retrieved from **www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf**

The supply of health professionals in rural and border areas is even lower than in urban and nonborder areas. The majority of rural Texas lacks psychiatrists, primary care physicians, pediatricians, obstetricians, gynecologists and other providers.[423] The difficulty of recruiting doctors to rural areas means many people must often travel long distances for even basic health care services that could prevent more costly illnesses in the future.

Access to specialty care is even more limited, particularly for the uninsured and individuals on Medicaid. According to the Texas Medical Association, the percentage of Texas physicians accepting new Medicaid patients has declined from 67% in 2000 to 31% in 2012.[424] Because rural providers often treat a higher percentage of Medicaid patients than do urban providers, the reduction of providers accepting Medicaid will create significant challenges for Medicaid enrollees seeking mental health services in rural communities. [425]

Behavioral Health Professionals in Texas

Mental health services in Texas are provided by a number of different mental health professionals including:[426]

- Psychiatrists
- Psychologists
- Social workers
- Licensed professional counselors
- Licensed marriage and family therapists
- Psychiatric nurses
- Licensed chemical dependency counselors
- Peer support specialists
- Promotores
- Psychiatric rehabilitation providers
- Pastoral counselors
- Occupational therapists

A brief description of each profession is provided below.

Psychiatrists

A psychiatrist is a medical doctor who specializes in the diagnosis, treatment and prevention of mental illness. Psychiatrists must complete a psychiatric residency and have a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) degree from an approved medical school and a license to practice medicine. Psychiatrists examine people biologically and psychologically, order medical tests, prescribe medications, provide psychotherapy and, when necessary, admit individuals to hospitals.[427]

Texas has a significant shortage of psychiatrists. In 2010, there were 1,687 psychiatrists, including 188 child psychiatrists. Most of those psychiatrists were concentrated along the I-35 corridor from Bexar County to Dallas County, and also in the Harris and Cherokee County areas; 181 counties had no psychiatrists. Of those 181 counties, 154 were rural counties containing a total population of 2,139,825. Though the number of psychiatrists has increased slightly over the past 25 years, the supply ratio, that is, the number of physicians per 100,000 residents, has decreased and has not kept pace with the state's population growth.[428]

Figure 73. Psychiatrists and Supply Ratios per 100,000

Year	Number	Texas	Rural	Urban	Border	Rural Border
1985	1,222	7.5	2.0	8.6	2.8	0.7
1990	1,264	7.4	2.1	8.4	3.0	0.0
1995	1,365	7.3	2.8	9.0	3.6	0.3
2000	1,422	7.0	3.0	8.0	3.3	0.8
2005	1,488	6.5	2.8	7.0	2.6	1.1
2010	1,687	6.6	2.7	7.2	2.5	0.5

Source: Texas Department of State Health Services, Center for Health Statistics, & Health Professions Resource Center. (April 2011). *Highlights: The supply of mental health professionals in Texas - 2010* (DSHS Publication No. 25-12347).

Child Psychiatrists

Although a psychiatrist does not have to be a child psychiatrist to treat children, child psychiatrists have additional training in treating children and their families. In 2010, 27.4% of the population – 6,956,043 people – were age 18 or younger, but there were only 188 child psychiatrists distributed across 37 of the state's 254 counties. The provider-to-patient ratio was a low 2.7 child psychiatrists per 100,000 children ages 0 to 18. As with all psychiatrists, most of the child psychiatrists were located along I-35 from Bexar County to Dallas County, with another cluster around Harris County. Bexar County had the most child psychiatrists of any county (35), followed by Harris County (34). Only six child psychiatrists practiced in the border counties (serving a population of 861,524 children). Only five child psychiatrists practiced in the rural counties in Texas, serving a population of 814,578 children. No child psychiatrists practiced in rural border counties, where 122,320 children live.[429]

Psychologists

A psychologist is a health care professional who diagnoses and treats mental, nervous, emotional and behavioral conditions. Psychologists study the behavior, emotions and thinking processes of individuals and groups to better understand their behavior. Psychologists work directly with individuals using diagnostic tests and intervention techniques to help them deal with their problems. In Texas, there are four categories of psychologists: licensed psychologist (LP), provisionally licensed psychologist (PLP), licensed specialist in school psychology (LSSP), and licensed psychological associate (LPA). A psychologist may hold more than one of these licenses. [430]

Although there has been an increase in the number of psychologists in Texas, rural areas, West Texas, South Texas, and the Panhandle areas have significant shortages. The largest concentration of psychologists is in Central Texas. In 2010, 5.3% of Texas' psychologists practiced in the 177 rural counties, where 12.4% of the population lived. In 2010, 103 counties had no psychologists; of those 103 counties, 96 were rural counties containing a total population of 750,046.[432]

Figure 74. Psychologists and Supply Ratios per 100,000

Year	Number	Texas	Rural	Urban	Border	Rural Border
2000	5,044	24.8	9.8	26.3	7.1	2.4
2005	5,567	24.2	10.2	26.3	7.6	3.0
2010	6,547	25.8	11.1	27.9	8.3	5.4

Source: Texas Department of State Health Services, Center for Health Statistics, & Health Professions Resource Center. (April 2011). *Highlights: The supply of mental health professionals in Texas -2010* (DSHS Publication No. 25-12347).

Social Workers

Social work is a profession that helps individuals, families, groups and communities modify their behaviors, emotions, attitudes, relationships and social conditions to restore and enhance their capacity to meet their personal and social needs.[432] Social workers apply specialized knowledge and skills in the areas of assessment, diagnosis and treatment of mental, emotional and behavioral conditions, including serious mental illness in adults and serious emotional disturbances in children. Treatment methods include the provision of individual, marital, couple, family and group therapy, and psychotherapy.[433]

In Texas, there are three levels of professional licensure for social workers and three specialty recognitions. Texas licensure titles include licensed baccalaureate social worker (LBSW), licensed master social worker (LMSW), and licensed clinical social worker (LCSW). The LCSW may provide all social work services, including clinical services such as diagnosing mental, emotional, behavioral, developmental and addictive conditions, developing treatment plans, and providing psychotherapy.[434]

In 2010, there were 16,962 licensed social workers in Texas. They were distributed throughout the state, although many West Texas counties did not have any social workers. In 2010, 46 counties had no social workers, compared with 35 counties in 1999. Of those 46 counties, 43 were rural with a total population of 199,413. While the number of social workers has increased since 2000, the supply ratios for social workers per 100,000 people have decreased from 71.5 in 2000 to 66.8 in 2010 due to population growth.[433]

Figure 75. Social Workers and Supply Ratios per 100,000

Year	Number	Texas	Rural	Urban	Border	Rural Border
2000	14,549	71.5	52.8	74.5	43.0	19.6
2005	15,687	68.2	45.1	71.7	42.4	23.1
2010	16,962	66.8	43.7	70.1	41.5	18.4

Source: Texas Department of State Health Services, Center for Health Statistics, & Health Professions Resource Center. (April 2011). *Highlights: The supply of mental health professionals in Texas -2010* (DSHS Publication No. 25-12347).

Licensed Professional Counselors

A licensed professional counselor (LPC) is a mental health professional who provides group and individual professional therapeutic services that involve the application of mental health, psychotherapeutic and human development principles to facilitate adjustment and development throughout life.[436] LPCs prevent, assess, evaluate and treat mental, emotional or behavioral conditions and associated distresses that interfere with mental health. They also conduct assessments and evaluations to establish treatment

goals and objectives, and plan, implement and evaluate treatment plans using counseling treatment interventions that include counseling, assessment, consulting and referral.[435]

A licensed professional counselor holds at least a master's degree in counseling or a counseling-related field, and also must complete 3,000 hours of supervised experience in the field of professional counseling.[438]

The number of licensed professional counselors increased from 10,036 in 2001 to 15,781 in 2010. In 2010, 44 counties had no licensed professional counselors, including 42 rural counties with a population of 184,932.[439]

Figure 76. Texas Licensed Professional Counselors and Supply Ratios per 100,000

Year	Number	Texas	Rural	Urban	Border	Rural Border
2001	10,036	48.5	31.3	51.3	18.3	13.3
2005	10,896	47.4	31.0	49.9	19.7	13.7
2006	13,954	59.5	38.8	62.6	29.2	23.3
2010	15,781	62.2	39.6	65.4	30.6	21.2

Source: Texas Department of State Health Services, Center for Health Statistics, & Health Professions Resource Center. (April 2011). *Highlights: The supply of mental health professionals in Texas -2010* (DSHS Publication No. 25-12347).

Licensed Marriage and Family Therapists

A licensed marriage and family therapist (LMFT) is a mental health professional who provides professional therapeutic services to individuals and groups that involve the application of family systems theories and techniques. Services may include marriage therapy, sex therapy, family therapy, child therapy, play therapy, individual psychotherapy, divorce therapy, mediation, group therapy, chemical dependency therapy, rehabilitation therapy, diagnostic assessment, hypnotherapy, biofeedback and related services.[440]

A licensed marriage and family therapist holds at least a master's degree in marriage and family therapy or its equivalent, and also must complete 3,000 hours of supervised experience in the field of marriage and family therapy services.[441] In 2010, there were 2,847 LMFTs located in 132 counties.

Psychiatric Nurses

The Board of Nursing identifies psychiatric nurses based on their employment in a "psychiatric/mental health/substance use" work area, or specialty. For the purposes of this report, psychiatric nurses are registered nurses who indicated that their work area was "psychiatric/mental health/substance use."

In 2010, there were 5,049 psychiatric nurses in Texas, and they accounted for 2.9% of all registered nurses, compared with 3.2% in 2005 and 5.0% in 1996. Even though the number of registered nurses has increased, both the numbers and the ratios of those who identify themselves as psychiatric nurses have decreased steadily over the past two decades. While some areas of Texas may seem to have an adequate number of psychiatric nurses, other areas – such as rural, West Texas, South Texas and Panhandle areas – had shortages based on supply ratios. In 2012, 130 counties had no psychiatric nurses, compared to 116 in 2005. One hundred and twelve of those were rural counties with a total population of 1,045,961. Almost all of those counties were in West Texas and the Panhandle. The supply

ratios for psychiatric nurses were lower in the border counties than they were in Texas as a whole and were much lower in the rural border counties.[442]

Figure 77. Psychiatric Nurses and Supply Ratios per 100,000

Year	Number	Texas	Rural	Urban	Border	Rural Border
1990	5,262	31.0	16.3	33.7	11.4	2.3
1996	5,136	26.9	19.6	28.1	9.6	1.8
2000	5,084	25.0	20.9	25.7	10.1	2.1
2005	4,602	20.0	17.2	20.4	7.5	2.1
2010	5,049	19.9	18.2	20.1	10.1	1.0

Source: Texas Department of State Health Services, Center for Health Statistics, & Health Professions Resource Center. (April 2011). *Highlights: The supply of mental health professionals in Texas -2010* (DSHS Publication No. 25-12347).

Licensed Chemical Dependency Counselors

A licensed chemical dependency counselor (LCDC) is a mental health professional who assists individuals or groups to develop an understanding of chemical dependency problems, define goals and develop action plans reflecting the individual's or group's interests, abilities and needs as affected by chemical dependency problems. Services may include the diagnosis of a substance use disorder. LCDCs are not authorized to treat individuals with a mental health disorder or provide family counseling to individuals whose problems do not include chemical dependency.[443]

A chemical dependency counselor must hold at least a two-year associate's degree with a course of study in human behavior/development and service delivery and must complete 4,000 hours of supervised experience working with chemically dependent persons. [444] In 2010, there were 7,242 licensed chemical dependency counselors in Texas.[445]

Figure 78. Licensed Chemical Dependency Counselors and Supply Ratios per 100,000

Year	Number	Texas	Rural	Urban	Border	Rural Border
2002	4,699	22.3	21.0	22.5	11.4	8.7
2005	4,186	18.2	17.3	18.3	10.8	9.4
2008	6,980	28.9	27.3	29.1	25.7	21.5
2010	7,242	28.5	27.1	28.7	25.6	29.4

Note: Starting in 2008, interns were included in the data for licensed chemical dependency counselors. In 2010, there were only 4,415 LCDC's who were not interns, for a ratio of 17.4

Source: Texas Department of State Health Services, Center for Health Statistics, & Health Professions Resource Center. (April 2011). *Highlights: The supply of mental health professionals in Texas -2010* (DSHS Publication No. 25-12347).

Peer Support Specialists

Peer support specialists are individuals whose personal experience with mental illness or substance use enables them to provide meaningful assistance and recovery support to other people with similar diagnoses. These self-identified individuals receive special training to engage their peers in a recovery process based on the principles of self-directed recovery. Peer support specialists provide a range of services that may include helping individuals access treatment and resources, developing a personal recovery plan, providing assistance with treatment, teaching and practicing new skills for coping, and providing encouragement and support throughout the recovery process.

Peer support specialists bring a perspective to treatment and recovery that cannot be replicated by those who have not personally experienced the challenges. Their ability to relate to the daily demands and stress of recovery and their personal methods for coping serve as a model for the individuals they work with, and provide an ongoing source of encouragement. Since the certification process began in Texas in 2010, over 240 certified peer specialists have been trained.[446] More information on peer support specialists and certified peer support specialists is available in Section 6. Best Practices.

Promotores(as)

Promotores(as) are community health workers often used in rural areas to promote health and wellness. The use of promotores(as) to increase awareness of mental health and wellness is expanding. In 2001, DSHS was directed by the Texas Legislature to develop a training and certification program for promotores(as) or community health workers. The cultural and linguistic awareness of promotores(as) increases their ability to connect with often hard to reach populations. More information on the training and certification program can be found on the department's website at **www.dshs.state.tx.us/mch/chw.shtm.**

Psychiatric Rehabilitation Providers

Psychiatric rehabilitation providers (commonly referred to as psych rehab consultants or psych rehab specialists) provide various types of services designed to restore community functioning and well-being of individuals with a mental health condition or psychiatric disability. These services promote recovery, full community integration and improved quality of life for persons with a mental health condition that impairs their ability to function in society in a meaningful way. The work is performed by numerous types of providers, including psychiatrists, social workers, psychologists, community support workers and occupational therapists. The services they provide may include social skills and communication training, basic living skills (hygiene, meals, safety, planning and chores), financial management (budgets), psychological support to clients and their families, assistance with housing, vocational training and social and family support.[447]

Pastoral Counselors

Through pastoral counseling programs, specially trained ministers, rabbis, priests, imams and other persons from various religious sectors provide counseling services for the members of their congregation or other persons requesting assistance. Some provide services through stand-alone counseling centers. Pastoral counselors frequently integrate modern psychological therapy services with religious training, providing a perspective that is not usually incorporated in traditional counseling services. Individuals providing these services may be specially licensed or certified as mental health professionals, but pastors are not required to obtain a separate license in order to provide counseling services to their members.[448]

Occupational Therapists

Occupational therapists provide a variety of services designed to help individuals develop the skills and supports necessary for independent, productive living, and reduce the need for hospitalization or commitment to a long-term medical, nursing

or psychiatric facility. Services include assistance with adaptations to home, workplace and school environments to support the individual's success; providing education programs and training; developing skills for employment; providing assistance with jobs and housing; and developing rehabilitation plans designed to promote an individual's optimal functioning. Therapists may help an injured or disabled person learn to bathe and dress independently, plan and cook a meal, navigate public transportation, balance a checkbook, and perform other typical daily living activities. They work closely with physical therapists, speech language pathologists, physicians, psychiatrists, case workers and nurses to develop and implement a treatment plan that is uniquely designed to address each person's needs.[449]

Occupational therapists hold a bachelor's, master's or doctorate degree. Certified occupational therapy assistants must obtain an associate degree. All occupational therapy providers must complete supervised fieldwork in a variety of settings and must pass a national and state certification examination.[450]

Appendix 1. List of Figures

Appendix 2. Additional Resources

Agency Websites

Texas Health and Human Services Commission (HHSC): **www.hhsc.state.tx.us/index.shtml**

Texas Department of State Health Services (DSHS): **www.dshs.state.tx.us**

Texas Department of Family and Protective Services (DFPS): **www.dfps.state.tx.us**

Texas Department of Aging and Disability Services (DADS): **www.dads.state.tx.us**

Texas Department of Assistive and Rehabilitative Services (DARS): **www.dars.state.tx.us/index.shtml**

Texas Department of Criminal Justice (TDCJ): **www.tdcj.state.tx.us**

Texas Juvenile Justice Department (TJJD): **www.tjjd.texas.gov**

Texas Education Agency (TEA): **www.tea.state.tx.us**

Texas Department of Housing and Community Affairs (TDHCS): **www.tdhca.state.tx.us**

Certified Peer Specialists

Copeland Center for Wellness and Recovery: **www.copelandcenter.com/**

Promotoras in Mental Health: **www.promotorasinmentalhealth.com/**

Institute for Recovery and Community Integration: **www.mhrecovery.org/services/peer.php**

Via Hope – Texas Mental Health Resource: **www.viahope.org/**

Promotores(as)

Migrant Health Promotion Training and Support for Promotores(as): **www.migranthealth.org/index.php?option=com_content&view=article&id=67&Itemid=65**

USA Center for Rural Public Health Preparedness: **www.rural-preparedness.org/index.aspx?page=fd089d35-bd02-4b2a-9ad7-15fc31c99b55**

Using the Promotora Model to Address Behavioral Health Disparities in Rural Communities: **www.nmha.org/action/disparities_meeting/Gonzalez.pdf**

Child Welfare and Mental Health

Child Welfare Information Gateway: **www.childwelfare.gov/systemwide/mentalhealth/**

Child Welfare League of America: **www.cwla.org/programs/bhd/mhdefault.htm**

Texans Care for Children: **www.texanscareforchildren.org/**

Children's Mental Health

National Children's Traumatic Stress Network: **www.nctsnet.org/**

National Federal of Families for Children's Mental Health: **www.ffcmh.org/**

National Institute of Mental Health, Child and Adolescent Mental Health: **www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/index.shtml**

Consumer and Family Organizations

Texas Catalyst for Empowerment: **www.viahope.org/resources/view/texas-catalyst-for-empowerment** or **www.mytce.org/**

Mental Health America: **www.mentalhealthamerica.net/**

Mental Health America – Texas: **www.newsite.mhatexas.org/**

National Alliance on Mental Illness: **www.nami.org/**

National Alliance on Mental Illness – Texas: **www.namitexas.org/**

National Empowerment Center: **www.power2u.org/**

Via Hope – Texas: **www.viahope.org/**

Criminal/Juvenile Justice and Mental Health

Council on State Governments Justice Center. Criminal Justice and Mental Health Consensus Project: **www.consensusproject.org**

National Center for Mental Health and Juvenile Justice: **www.ncmhjj.com**

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation: **www.gainscenter.samhsa.gov/**

Texas Appleseed: **www.texasappleseed.net/**

Texas Criminal Justice Coalition: **www.criminaljusticecoalition.org/fair_defense/mental_illness**

Texas Public Policy Foundation: **www.texaspolicy.com/**

Cultural and Linguistic Competency

Georgetown University National Center for Cultural Competence: **www.nccc.georgetown.edu**

Hogg Foundation for Mental Health. *Enhancing the delivery of health care: Eliminating health disparities through a culturally and linguistically centered integrated health care approach*: **www.hogg.utexas.edu/uploads/documents/FinalReport%20-ConsensusStatementsRecommendations.pdf**

NAMI Multicultural Action Center: **www.nami.org/Template.cfm?Section=Multicultural_Support&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=56&ContentID=25443**

U.S. Department of Health & Human Services: Office of Minority Health **www.minorityhealth.hhs.gov**

U.S. Surgeon General's Office Supplemental Report on Mental Health: Culture, Race, and Ethnicity: **www.surgeongeneral.gov/library/mentalhealth/cre**

Technical Assistance Partnership for Child and Family Mental Health (TA Partnership): **www.tapartnership.org/COP/CLC/default.php**

Early Childhood and Mental Health

Texas Association for Infant Mental Health: **www.taimh.org/**

Zero to Three: **www.zerotothree.org/child-development/early-childhood-mental-health/**

General Information on Mental Health and Substance Use

Mental Health, United States, 2010. Available through the Substance Use and Mental Health Services Administration: **www.store.samhsa.gov/product/Mental-Health-United-States-2010/SMA12-4681**

National Association of State Mental Health Program Directors – National Research Institute: **www.nri-inc.org/**

National Institute of Mental Health: **www.nimh.nih.gov/index.shtml**

Substance Use and Mental Health Services Administration, Center for Mental Health Services Uniform Reporting System Output Tables: **www.samhsa.gov/dataoutcomes/urs**

Substance Use and Mental Health Services Administration: **www.samhsa.gov/**

Housing

Coalition for Supportive Housing: **www.csh.org/csh-in-the-field/texas**

Neighborhood Housing and Community Development: **www.austintexas.gov/department/permanent-supportive-housing-initiative**

Technical Assistance Collaborative: **www.tacinc.org/about-tac/**

Integrated Physical and Mental Health Care

Advancing Integrated Mental Health Solutions (AIMS) Center: **www.uwaims.org/index.html**

Center for Integrated Health Solutions, National Council on Community Behavioral Healthcare: **www.thenationalcouncil.org/cs/center_for_integrated_health_solutions**

Hogg Foundation for Mental Health: **www.hogg.utexas.edu/initiatives/integrated_health_care.html**

Mental Health in Schools

Center for Health and Health Care in Schools: **www.healthinschools.org/**

Texas Education Agency: **www.tea.state.tx.us/index2.aspx?id=7912&menu_id=2147483656**

UCLA School Mental Health Project: **www.smhp.psych.ucla.edu/**

University of Maryland Technical Assistance Center on School Mental Health: **www.schoolmentalhealth.org/AboutUs.html**

Mental Health Workforce Development

Center for Health and Health Care in Schools: **www.healthinschools.org/**

SAMSHA, An Action Plan for Behavioral Health Workforce Development: **www.samhsa.gov/workforce/annapolis/workforceactionplan.pdf**

The Annapolis Coalition, Action Plan on Behavioral Health Workforce Development: **www.annapoliscoalition.org/action_plan.aspx**

US National Library of Medicine National Institutes of Health, Developing the mental health workforce: **www.ncbi.nlm.nih.gov/pubmed/21190075**

Recovery and Wellness

National Empowerment Center: **www.power2u.org/**

National Council on Alcoholism and Drug Dependence, Inc.: **www.ncadd.org/index.php/recovery-support/overview**

SAMHSA: **www.samhsa.gov/newsroom/advisories/1112223420.aspx**

Suicide Prevention

A Report of the Surgeon General: 2012 National Strategy for Suicide Prevention: **www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf**

Preventing Suicide: A toolkit for High Schools: **www.store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669**

SAMHSA – Suicide Prevention: **www.samhsa.gov/prevention/suicide.aspx**

Telemedicine and Telehealth

American Telemedicine Association: **www.americantelemed.org/i4a/pages/index.cfm?pageID=3281**

University of Colorado Denver Telemental Health Guide: **www.tmhguide.org/**

Veterans Services

Make the Connection: Share experiences and supports for veterans: **www.maketheconnection.net/conditions/suicide?gclid=CI299Pia-rICFZGiPAodhj0A_Q**

Texas Veterans Commission: **www.tvc.state.tx.us/Home.aspx**

US. Department of Veterans Affairs: **www.va.gov**

Appendix 3. Glossary

Common Behavioral Health Terms

Acute: Refers to a disease or condition that develops rapidly and is intense and of short duration.

Affect: Feeling or emotion, especially as manifested by facial expression or body language.

Alternative therapy: Mental health care that is used instead of or in addition to conventional mental health services.

Anti-anxiety medications: Used to treat anxiety disorders. Anti-anxiety medications include the benzodiazepines and buspirone (BuSpar).

Anticonvulsant: Often used instead of or in addition to traditional bipolar medications to treat bipolar disorder. Anticonvulsants are as effective in non-rapid-cycling bipolar disorder as lithium and appear to be superior to lithium in rapid-cycling bipolar disorder.

Antidepressant medications: Used to reduce the symptoms of depression. See MAOs, SSRIs, Tricyclics and classes of antidepressants.

Antimanic medications: Used to treat symptoms of mania in bipolar disorder.

Antipsychotic (neuroleptic) medications: Used to treat symptoms of a psychotic illness such as schizophrenia or certain stages of bipolar disorder.

Anxiety: A sense of fear, nervousness, and apprehension about something.

Anxiety disorders: A group of chronic disorders ranging from feelings of uneasiness to immobilizing bouts of terror. Anxiety disorders include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), phobias, and generalized anxiety disorder.

Asthenia: A symptom represented by loss of bodily strength and lack of energy.

Behavioral health care: Continuum of services for individuals at risk of, or currently living with, one or more mental health conditions, addictive disorders or other behavioral health disorders.

Behavioral therapy: Therapy focusing on changing unwanted behaviors through rewards, reinforcements and desensitization. Desensitization, or exposure therapy, is a process of confronting something that arouses anxiety, discomfort or fear and overcoming the unwanted responses.

Biomedical treatment: Treatment involving medication. The kind of medication a psychiatrist prescribes varies with the disorder and the individual being treated; also referred to as psychopharmachology.

Bipolar disorder: A mood disorder in which a person alternates between episodes of major depression and mania.

Caregiver: A person who has special training to help people with mental health conditions. Caregivers can be, but are not required to be, mental health professionals. Caregivers may include social workers, teachers, psychologists, psychiatrists, family members and mentors.

Case manager: An individual who organizes and coordinates services and supports for persons with mental health needs and their families. (Also: service coordinator, advocate and facilitator.)

Chronic: Refers to a disease or condition that persists over a long period of time.

Cognitive therapy: Aims to identify and modify distorted thinking patterns that can lead to feelings and behaviors that may be troublesome, self-defeating, or self-destructive.

Cognitive/behavioral therapy: A combination of cognitive and behavioral therapies that help people identify and modify maladaptive thought patterns, beliefs, and behaviors.

COBRA (Consolidated Omnibus Budget Reconciliation Act): An act that allows workers and their families to continue their employer-sponsored health insurance for a certain amount of time after terminating employment.

Consumer: A person who is obtaining conventional or alternative treatment or support for a mental health condition.

Cyclothymia: A mood disorder characterized by periods of mild depression followed by periods of normal or slightly elevated mood.

DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition): A book published by the American Psychiatric Association that gives general descriptions and characteristic symptoms of different mental illnesses. Physicians and other mental health professionals use the DSM-IV to confirm diagnoses for mental illnesses.

Day treatment: Treatment including special education, counseling, parent training, vocational training, skill building, crisis intervention and recreational therapy for at least four hours a day.

Deductible: The amount an individual must pay for health care expenses before insurance (or a self-insured company) begins to pay its contract share. Often insurance plans are based on yearly deductible amounts.

Delusion: An idiosyncratic belief or impression that is maintained despite being contradicted by what is generally accepted as reality.

Major depressive disorder (MDD): A mood disorder characterized by intense feelings of sadness and hopelessness that persist beyond a few weeks.

Diagnostic evaluation: The assessment of a person's mental, social and psychological functionality.

Disease: An impairment of health or functioning often characterized by physical findings and specific symptoms that are common among a number of individuals who ultimately receive a diagnosis of the disease in question.

Disorder: An interruption of the normal structure or function of the body or mind that is manifested by a characteristic set of physical findings and of specific symptoms.

Dose: A quantity to be administered at one time, such as a specified amount of medication.

Dually diagnosed: An individual who has both a substance use disorder and an emotional or mental health condition. This term is also used to refer to an individual living with one or more developmental or intellectual disabilities and a substance use disorder or emotional or mental health condition.

Dysphoria, dysphoric: A mood state characterized by agitation, anger, impatience, anxiety or uneasiness.

Dysthymic disorder: A mood disorder characterized by feelings of sadness, loss of interest or pleasure in one's usual activities, and some or all of the following: altered appetite, disturbed sleep patterns, lack of energy, decreased ability to concentrate and feelings of hopelessness. Symptoms are less severe than those of major depressive disorder.

Electroconvulsive therapy (ECT): A highly controversial technique using low-voltage electrical stimulation of the brain to treat some forms of major depression, acute mania and some forms of schizophrenia.

Employee assistance plan (EAP): Resources provided by employers either as part of, or separate from, employer-sponsored health plans. EAPs typically provide preventive care measures, various health care screenings and wellness activities.

Euphoria: A feeling of happiness, confidence or well-being sometimes exaggerated in mood disorders such as mania.

Euthymia: Mood in the "normal" range, without manic or depressive symptoms.

Evidence-based practices: a combination of: (1) best research evidence, (2) best clinical experience, and (3) consistent with patient values.

Food and Drug Administration (FDA): A federal agency whose responsibilities include, protecting the public health by assuring the safety, efficacy, and security of prescription and over-the-counter drugs. The FDA also helps speed innovations that make medicines more effective, safer, and more affordable; and provides accurate, science-based information to the public.

Generalized anxiety disorder (GAD): An anxiety disorder characterized by consistent feelings of anxiety for a period of at least six months and accompanied by symptoms such as fatigue, restlessness, irritability and sleep disturbance.

Generic: drugs that do not have a brand name but are typically required to be equivalent to a brand-name counterpart, with the same active ingredients, strength and dosage form and have the same medical effect. Some drugs are protected by patents and supplied by only one company. When the patent expires, other manufacturers can produce its generic version.

Genetic: Inherited; passed from parents to offspring through genes.

Group-model health maintenance organization (HMO): A health care model involving contracts with physicians organized as a partnership, professional corporation or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.

Group therapy: Therapy involving groups of usually four to twelve people who have similar experiences and who meet regularly with a mental health professional. The mental health professional uses the emotional interactions of the group's members to help them get relief from distress and possibly modify their behavior.

HMO (health maintenance organization): A type of managed care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Services are furnished through a network of providers.

Hallucination: The perception of something, such as a sound or visual image, that is not actually present.

Hypersomnia: Excessive sleepiness; prolonged nighttime sleep, difficulty staying awake during the day.

Hypomania: A mild, nonpsychotic form of mania, characterized by increased levels of energy, physical activity and talkativeness.

Monoamine oxidase inhibitors (MAOIs): The first type of antidepressants on the market. Researchers believe MAOIs lessen symptoms of depression by preventing the enzyme monoamine oxidase from metabolizing the neurotransmitters norepinephrine, serotonin and dopamine in the brain. As a result, these levels remain high in the brain, boosting mood.

Magnetic resonance imaging (MRI): An imaging technique that uses magnetic fields to take pictures of the structure of the brain.

Mania: Feelings of intense mental and physical hyperactivity, elevated mood and agitation.

Manic-depression: See bipolar disorder.

Managed care: An organized system for delivering comprehensive health services that allows the managed care entity to determine what services will be provided to an individual in return for a prearranged financial payment. Generally, managed care controls health care costs and discourages unnecessary hospitalization and overuse of specialists. The health plan operates under contract to a payer.

Medicaid: A federal-state funded health insurance assistance program for low-income children and families and people with disabilities.

Medicare: A federal insurance program serving individuals with disabilities and persons over the age of 65. Most costs are paid via trust funds that beneficiaries pay into over the courses of their lives; small deductibles and co-payments are required.

Medication therapy: Prescription, administration, assessment of drug effectiveness and monitoring of potential side effects of psychotropic medications.

Mental health professionals: A mental health professional is a health care practitioner who offers services for the purpose of improving an individual's mental health or to treat mental health conditions. This broad category includes psychiatrists, clinical psychologists, clinical social workers, psychiatric nurses, mental health counselors, professional counselors, pharmacists and many other professionals.

Mental illness: A health condition that disrupts a person's thinking, feelings, mood, ability to relate to others or daily functioning and causes the person distress.

Mixed states: The occurrence of symptoms of mania and depression together. A person may feel sad and hopeless while at the same time feeling extremely energized. Also called dysphoric mania, mixed mania or agitated depression.

Mood disorders: Disorders in which the essential feature is a disturbance of mood manifested as one or more episodes of mania, hypomania, depression, or some combination of bipolar I and bipolar II disorders, cyclothymic disorder, major depressive disorder and dysthymic disorder.

Mood stabilizer: Lithium and/or an anticonvulsant for treatment of bipolar disorder, often combined with an antidepressant.

Neurotransmitters: Chemical substances that transmit information from one neuron to another by crossing the space between two adjacent neurons

Obsessive-compulsive disorder (OCD): An anxiety disorder characterized by recurrent thoughts, feelings, ideas or sensations (obsessions) or repetitive, ritualized behaviors (compulsions).

Off-label use: Medications used for a different condition, different dosage or other use not mentioned in the FDA-approved labeling. Off-label use is not prohibited by the FDA.

Panic disorder: An anxiety disorder in which people have feelings of terror, rapid heartbeat and rapid breathing that strike suddenly and repeatedly without reasonable cause.

Peer support specialist: Individuals whose personal experience and struggles with mental illness or substance use enables them to provide assistance and recovery support to other people with similar diagnoses.

Permanent supportive housing: An evidence-based practice that combines stable and affordable living arrangements with access to flexible health and human services designed to promote recovery for people with behavioral health conditions.

Preferred provider organization (PPO): A health plan in which consumers may use any health care provider on a fee-for-service basis. Consumers will be charged more for visiting providers outside of the PPO network than for visiting providers in the network.

Phobia: An intense or irrational fear of something. Examples of phobias include fear of closed-in places, heights, escalators, tunnels, highway driving, water, flying, dogs and injuries involving blood.

Primary care physician (PCP): The PCP is responsible for monitoring an individual's overall medical care and referring the individual to more specialized physicians for additional care. Typically encompassed in the following specialties: group practice, family practice, internal medicine, obstetrics/gynecology and pediatrics.

Psychiatric/psychotherapeutic/psychotropic medications: Drugs used to treat the symptoms of mental health conditions.

Psychiatrist: A medical doctor who specializes in the diagnosis, treatment and prevention of mental illness.

Psychologist: A health care professional who diagnoses and treats mental, nervous, emotional and behavioral conditions and ailments.

Psychosis: A severe mental health condition in which thought and emotions are so impaired that a person loses contact with external reality.

Psychotherapy: A treatment method for mental health concerns in which a mental health professional and a consumer discuss needs and feelings to find solutions. Psychotherapy can help individuals change their thought or behavior patterns and understand how past experiences affect current behaviors.

Rapid cycling: Experiencing changes in mood from mania to major depression, or mixed states, within hours, days or months.

Receptor: A molecule that recognizes specific chemicals, including neurotransmitters and hormones, and transmits the message into the cell on which the receptor resides.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Relapse: The reoccurrence of symptoms of a disease. A deterioration in health after a temporary improvement.

Serotonin: A neurotransmitter that most likely contributes to the regulation of sleep, appetite and mood. People experiencing depression or anxiety often have a serotonin deficiency.

Signs: Indications of illness that are observed by the examiner rather than reported by the individual.

Somnolence: Sleepiness, drowsiness.

Selective serotonin reuptake inhibitors (SSRIs): A class of antidepressants that act within the brain to increase the amount of the neurotransmitter, serotonin (5-hydroxytryptamine or 5-HT), in the synaptic gap by inhibiting its reuptake.

Stigma: A negative stereotype about a group of people.

Symptom: Something that indicates the presence of a disease.

Syndrome: A collection of physical signs and symptoms that, when occurring together, are characteristic of a specific condition.

Tricyclic antidepressants (TCA): A class of antidepressant drugs first used in the 1950s. They are named after the drugs' molecular structure, which contains three rings of atoms. Tricylic antidepressants are generally thought to work by inhibiting the re-uptake of the neurotransmitters norepinephrine, dopamine or serotonin by nerve cells.

Third-party payer: A public or private organization that is responsible for the health care expenses of another entity.

Titrate: To gradually increase or decrease the dose of a drug in order to reach a target dosage.

Vocational rehabilitation services: Services that include job finding, development, assessment and enhancement of work-related skills, as well as provision of job experience to individuals.

Sources:

Institute of Medicine

National Institute of Mental Health

U.S. Dept. of Health and Human Services

Substance Abuse Mental Health Services Administration (SAMHSA)

Various medical dictionaries

Resiliency and Disease Management (RDM) Service Descriptions

Crisis intervention services are interventions provided in response to a crisis in order to reduce symptoms of severe and persistent mental illness or serious emotional disturbance and to prevent admission of an individual to a more restrictive environment. This service may be delivered to anyone experiencing a mental health crisis. This service does not require prior authorization.

Pharmacological management services include supervision of administration of medication, monitoring of effects and side effects of medication, and assessment of symptoms. Includes one psychiatric evaluation per year.

Routine case management includes basic facilitation of access to resources and services and coordination of services with the individual, as well as administration of instruments to assess treatment progress.

Rehabilitative case management provides a variable level of integrated support to people including assistance in accessing medical, social, psychological, educational and other appropriate support services. Where routine case management is similar to basic service coordination and has higher caseloads, rehabilitative case management is similar to the Medicaid service of targeted case management.

Medication training and support services includes education on diagnosis, medications, monitoring and management of symptoms, and side effects.

Counseling (specifically, cognitive behavioral therapy) is provided to resolve a concrete problem in daily functioning or treat symptoms resulting from maladaptive thoughts, feelings, interpersonal disturbances and experiences. Counseling is intended to be brief, time-limited and focused.

Supported employment provides individualized assistance in choosing and obtaining employment at integrated work sites in the community of the consumer's choice. It includes supports provided by identified staff that will assist individuals in keeping employment and finding another job as necessary. This includes skills training designed to address the symptoms of mental illness affecting an individual's ability to obtain and retain employment, as well as vocational-specific training.

Supported housing provides individualized assistance in choosing and obtaining integrated housing in the community of the consumer's choice. It also includes supports provided by staff that assist individuals in retaining housing or finding new housing as necessary. This includes skills training related to addressing the symptoms of mental illnesses that affect the person's ability to obtain and retain housing, as well as housing support services such as locating housing and assistance with moving.

Day programs for acute needs are site-based rehabilitative day programs that provide short-term, intensive treatment in a highly structured environment to individuals who require multidisciplinary treatment in order to stabilize acute psychiatric symptoms and avoid placement in a more restrictive setting. Day programs for acute needs are generally provided in settings such as crisis stabilization units and crisis residential settings.

For additional RDM services descriptions, please see the following link: **www.dshs.state.tx.us/mhprograms/RDMClinGuide.shtm**

Endnotes

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Mission

The Hogg Foundation for Mental Health advances mental wellness for the people of Texas as an impactful grantmaker and catalyst for change.

Hogg Foundation *for* Mental Health

ADVANCING RECOVERY AND WELLNESS IN TEXAS

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The Hogg Foundation encourages and appreciates comments and corrections as well as ideas for improving this guide. If this document is found useful to the community, the foundation will consider updating it prior to future legislative sessions. Specific comments should reference the applicable section and page number(s). Please include citations for all factual corrections or additional information. All comments and recommendations should be emailed to **Hogg_Guide@austin.utexas.edu**